Steinhouse

95TH CONGRESS
2d Session
HOUSE OF REPRESENTATIVES
REPORT
No. 95-1479

p. 39
p. 64
p. 66
p. 75
p. 100
p. 107

HEALTH MAINTENANCE ORGANIZATION AMENDMENTS OF 1978

REPORT

BY THE

COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE

together with

SEPARATE AND DISSENTING VIEWS

[To accompany H.R. 13655]

[And Including Cost Estimate of the Congressional Budget Office]

AUGUST 11, 1978.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

U.S. GOVERNMENT PRINTING OFFICE
32-310 O WASHINGTON : 1978

COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE

HARLEY O. STAGGERS, West Virginia, *Chairman*

JOHN E. MOSS, California
JOHN D. DINGELL, Michigan
PAUL G. ROGERS, Florida
LIONEL VAN DEERLIN, California
FRED B. ROONEY, Pennsylvania
JOHN M. MURPHY, New York
DAVID E. SATTERFIELD III, Virginia
BOB ECKHARDT, Texas
RICHARDSON PREYER, North Carolina
CHARLES J. CARNEY, Ohio
RALPH H. METCALFE, Illinois
JAMES H. SCHEUER, New York
RICHARD L. OTTINGER, New York
HENRY A. WAXMAN, California
ROBERT (BOB) KRUEGER, Texas
TIMOTHY E. WIRTH, Colorado
PHILIP R. SHARP, Indiana
JAMES J. FLORIO, New Jersey
ANTHONY TOBY MOFFETT, Connecticut
JIM SANTINI, Nevada
ANDREW MAGUIRE, New Jersey
MARTY RUSSO, Illinois
EDWARD J. MARKEY, Massachusetts
THOMAS A. LUKEN, Ohio
DOUG WALGREN, Pennsylvania
BOB GAMMAGE, Texas
ALBERT GORE, Jr., Tennessee
BARBARA A. MIKULSKI, Maryland

SAMUEL L. DEVINE, Ohio
JAMES T. BROYHILL, North Carolina
TIM LEE CARTER, Kentucky
CLARENCE J. BROWN, Ohio
JOE SKUBITZ, Kansas
JAMES M. COLLINS, Texas
LOUIS FREY, Jr., Florida
NORMAN F. LENT, New York
EDWARD R. MADIGAN, Illinois
CARLOS J. MOORHEAD, California
MATTHEW J. RINALDO, New Jersey
W. HENSON MOORE, Louisiana
DAVE STOCKMAN, Michigan
MARC L. MARKS, Pennsylvania

W. E. Williamson, *Chief Clerk and Staff Director*
Kenneth J. Painter, *First Assistant Clerk*
Eleanor A. Dinkins, *Assistant Clerk*

Professional Staff

Elizabeth Harrison
Jeffery H. Schwartz
Brian R. Moir
Karen F. Nelson
Ross D. Ain
Christopher E. Dunne
William M. Kitzmiller
Mark J. Raabe
Thomas M. Ryan
James S. Cowen

Subcommittee on Health and the Environment

PAUL G. ROGERS, Florida, *Chairman*

DAVID E. SATTERFIELD III, Virginia
RICHARDSON PREYER, North Carolina
JAMES H. SCHEUER, New York
HENRY A. WAXMAN, California
JAMES J. FLORIO, New Jersey
ANDREW MAGUIRE, New Jersey
EDWARD J. MARKEY, Massachusetts
RICHARD L. OTTINGER, New York
DOUG WALGREN, Pennsylvania
HARLEY O. STAGGERS, West Virginia
(Ex Officio)

TIM LEE CARTER, Kentucky
JAMES T. BROYHILL, North Carolina
EDWARD R. MADIGAN, Illinois
JOE SKUBITZ, Kansas
SAMUEL L. DEVINE, Ohio (Ex Officio)

Stephan E. Lawton, *Chief Counsel*
Robert W. Maher, *Director of Research and Planning*
Jo Anne Glisson, *Senior Staff Associate*
Donald W. Dalrymple, *Assistant Counsel*
William V. Corr, *Assistant Counsel*
Stephen J. Connolly, *Senior Staff Associate*
Burke Zimmerman, *Research Associate*
Robert M. Crane, *Senior Staff Associate*
Frances de Peyster, *Minority Staff Associate*
David S. Abernethy, *Minority Staff Associate*

CONTENTS

95TH CONGRESS } HOUSE OF REPRESENTATIVES { REPORT
2d Session } { No. 95-1479

HEALTH MAINTENANCE ORGANIZATION AMENDMENTS OF 1978

AUGUST 11, 1978.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. STAGGERS, from the Committee on Interstate and Foreign Commerce, submitted the following

REPORT

together with

SEPARATE AND DISSENTING VIEWS

[To accompany H.R. 13655]

[Including cost estimate of the Congressional Budget Office and oversight findings and recommendations of the Committee on Government Operations]

The Committee on Interstate and Foreign Commerce, to whom was referred the bill (H.R. 13655) to amend the Public Health Service Act to revise and extend the program of assistance under that Act for health maintenance organizations, having considered the same, reports favorably thereon with amendments and recommends that the bill as amended do pass.

The amendments (stated in terms of the page and line numbers of the introduced bill) are as follows:

Page 2, lines 15 and 16, strike out ", $25,000,000 for the fiscal year ending September 30, 1979".

Page 3, in lines 18 and 19 strike out "months" and insert in lieu thereof "month".

Page 5, strike out line 20 and all that follows through line 2 on page 6 and insert in lieu thereof the following:

> (e) Section 1302(1) is amended by inserting before the second sentence the following: "Such term does not include a health service which the Secretary, upon application of a health maintenance organization, determines is unusual and infrequently provided and not necessary for the protection of

individual health. The Secretary shall publish in the Federal Register each determination made by him under the preceding sentence."

Page 6, line 21, strike out "its".

Page 8, insert after line 6 the following:

(d) The amendments made by this section shall only be effective for fiscal years beginning on or after October 1, 1978.

Page 8, insert after line 20 the following:

(e) The amendments made by this section shall only be effective for fiscal years beginning on or after October 1, 1978.

Page 11, insert after line 5 the following:

"(3) The authority of the Secretary to make loans under subsection (a) shall be effective for any fiscal year only to such extent or in such amounts as are provided in advance in appropriation Acts.

Page 12, line 11, insert "(a)" before "Title".

Page 14, strike out the close quotation marks and the period following in line 11 and insert after line 11 the following:

"(c) The authority of the Secretary to enter into contracts under subsections (a) and (b) shall be effective for any fiscal year only to such extent or in such amounts as are provided in advance by appropriation Acts.".

Page 14, insert after line 13 the following:

(c) The amendments made by this section shall only be effective for fiscal years beginning on or after October 1, 1979.

Page 19, insert after line 13, the following:

(c) Section 1903(m)(1)(B) of the Social Security Act is amended by striking out "shall be administered through the Assistant Secretary for Health and in the Office of the Assistant Secretary for Health, and the administration of such duties and functions".

Page 19, insert after line 13, the following new section:

EMPLOYEE HEALTH BENEFITS PLANS

SEC. 14. (a) Section 1310(d)(1) (as amended by section 12) is amended by (1) striking out "and" at the end of clause (A), and (2) by inserting before the period at the end a comma and the following: "and (C) an entity described in paragraph (6)(B) of this subsection which has (i) received a waiver under such paragraph from the requirements of paragraph (6) of section 1301(c), and (ii) has provided assurances satisfactory to the Secretary that it provides basic and supplemental health services to its members in the manner prescribed by section 1301(b), that it is operated in the manner prescribed by section 1301(c), that, except with respect to the requirements of paragraph (6) of section 1301(c),

it is organized in the manner prescribed by section 1301(c), and that it will meet the requirements of paragraphs (2), (3), and (4) of this subsection".

(b) Section 1310(d) (as amended by section 12) is amended by adding after paragraph (5) the following new paragraph:

"(6)(A) For purposes of paragraph (1) of this subsection, the Secretary may, upon application, grant a waiver to an entity described in subparagraph (B) from the requirements of section 1301(c)(6) upon such terms and conditions as the Secretary may determine are appropriate if the entity (i) provided, before the expiration of one hundred and eightly days after the date of the enactment of this paragraph, notice to the Secretary of its intent to apply to be a qualified health maintenance organization, and (ii) made such an application before the expiration of eighteen months after such date of enactment. No grant, contract, loan, or loan guarantee may be made under this title for an entity granted a waiver under this subparagraph.

"(B) An entity eligible to apply for a waiver under subparagraph (A) is a health maintenance organization (as defined in regulations promulgated under section 1122 of the Social Security Act as in effect on the day before the date of enactment of this paragraph) (i) which is operated (but not as a separate legal entity) either by a commercial insurance carrier or a nonprofit carrier which provides hospital service benefits or medical or surgical benefits, or both, (ii) with respect to which Federal financial assistance has not been provided under this Act, and (iii) which on July 1, 1978, was engaged in providing basic health care services (as defined in regulations promulgated under such section 1122 as so in effect) to the organization's members."

(c) Section 1310(b) is amended by adding at the end the following: "The Secretary, as a condition to approving as a qualified health maintenance organization for an area for purposes of this section an entity which is described in subsection (d)(1)(C) and which provides basic and supplemental health services in a manner described in paragraph (1) or (2) of this subsection, may require the health benefits plan of each employer subject to subsection (a) which has at least 25 employees residing in such area to include in such plan at least two qualified health maintenance organizations which provide such services in such area in such manner when at least two such organizations are willing to be included in such plan".

I. Legislative Background

Legislation to amend Title XIII of the Public Health Service Act to revise and extend the program of assistance under that Act for health maintenance organizations (HMO's), H.R. 13266, was

introduced on June 22, 1978 by Mr. Rogers, Chairman of the Subcommittee on Health and the Environment. Hearings were conducted on H.R. 13266 and all similar or identical bills on June 30, 1978. At that time, testimony was received from the following witnesses:

I. Hale Champion, Under Secretary, Department of Health, Education and Welfare

II. Gregory A. Ahart, Director, Human Resources Division, General Accounting Office

III. A panel consisting of: Thomas J. Ernst, Vice President, St. Louis Metro Health Plan, St. Louis, Missouri. Roger W. Birnbaum, Executive Director, Rutgers Community Health Plan, New Brunswick, New Jersey

IV. A panel consisting of: James Roberts, M.D., Medical Director, Genesee Valley Group Health Association, Rochester, New York. Larry Hoffheimer, American Group Practice Association. W. Palmer Dearing, M.D., Medical Consultant, Blue Cross Association. William G. Kopit, American Association of Foundations for Medical Care. Calvin Johnson, Health Insurance Association of America. Roger Graham, Assistant Vice President for Professional Affairs, National Association for Blue Shield Plans. John G. Smillie, M.D., Permanente Medical Group, Kaiser Foundation Health Plan.

The bill was subsequently considered in open executive sessions by the Subcommittee on Health and the Environment, amended, reported and reintroduced as a clean bill, H.R. 13655, on July 22, 1978, by Rogers and eleven other members of the Subcommittee.

H.R. 13655 was considered by the Interstate and Foreign Commerce Committee on August 8, 1978, amended and ordered reported by a vote of 17 to 5.

II. Summary of Legislation

The purpose of this legislation is to amend and extend Title XIII of the Public Health Service Act which provides a program of assistance for health maintenance organizations (HMO's). This title was established by Public Law 93–222, the "Health Maintenance Organization Act of 1973."

As approved by the Committee, H.R. 13655 would amend existing law in the manner described below.

(1) It would extend the authorizations of appropriations for making grants and contracts to support entities desiring to become HMO's and HMO's for two fiscal years. Sixty-three million dollars would be authorized in both FY 1980 and FY 1981.

(2) The requirements related to an HMO's provision of services would be modified. The HMO would be allowed to collect payments from a workmen's compensation or insurance program for services covered by those programs. The restrictions on an HMO's ability to contract for physicians' services would be reduced during the HMO's first four years. An HMO would not be required to assume financial responsibility for services provided by another organization if the member intentionally left the area served by the HMO. Provisions would be added to modify the requirements that HMO's provide basic health services in the case of a disaster or similar occurrence or in the

case where a service is unusual or infrequently performed and not necessary to protect the health of the individual.

(3) It would modify certain HMO organizational requirements including allowing an HMO to experience rate student members, requiring an HMO to have certain administrative and managerial arrangements and capabilities, authorizing the Secretary to establish rules for the enrollment of medicaid beneficiaries, and modifying the policy-making body requirements for public HMO's.

(4) The authority for grants and loan guarantees for initial development would be amended to allow an HMO to be eligible for its establishment and up to $600,000 to support each significant expansion of membership or areas served; and amend the authority for grant support for HMO feasibility studies to allow grants regardless of the financial position of the applicant.

(5) It would expand the loan and loan guarantee support that may be provided to an HMO for its initial costs of operation from $2.5 to $4.0 million or, in any one year from $1 million to $2 million; and extend authority for this loan and loan guarantee support through September 30, 1981.

(6) Each employer which provides payroll deductions as a means of paying employees contributions for health benefits or which provides employees a health benefits plan would be required to payroll deduct the employees' contribution to the HMO upon the request of the employee.

(7) It would allow funds under section 319, "Migrant Health" and section 330, "Community Health Centers," of the Public Health Service Act to be used for grants for the planning and development of health services to be provided on a prepaid basis, or for the provision of health services on a prepaid basis.

(8) A program of loan and loan guarantee support for the acquisition and construction of ambulatory health care facilities would be established. Support would be limited to $2.5 million.

(9) It would establish a program of technical assistance and a National Health Maintenance Organization Intern Program for the purpose of training individuals to become administrators and medical directors of HMO's.

(10) The requirement that the qualification and compliance function be located in the Office of the Assistant Secretary for Health would be deleted.

(11) It would require that all qualified HMO's must provide the Secretary with ownership information and with related information to demonstrate that the HMO is fiscally sound and to allow for the examination of transactions between the HMO and a party in interest.

(12) It would extend to state and local officers or employees who are responsible for the expenditure of substantial amounts of Medicaid funds the conflict-of-interest provisions which apply to Federal officers or employees.

(13) The capital expenditure review provisions of the Social Security Act (section 1122) would be amended to provide that HMO's be covered equally with other health care institutions.

(14) Finally, it would authorize the Secretary to waive the policy-making body composition requirements of Title XIII for certain

HMO's which are part of an insurance company or Blue Cross plan and were in operation as of July 1, 1978. Eligible HMO's would have one and one half years to apply for qualification under the amendment. The Secretary may impose such terms and conditions on the HMO as he deems appropriate; and in areas served by an HMO which receives a waiver the employers may be required to offer two HMO's of the same type as that HMO which received the waiver.

III. Cost of the Legislation

As reported by the Committee, H.R. 13655 provides authorizations of appropriations of $63 million for both fiscal years 1980 and 1981.

H.R. 12460, the "Health Centers Amendments of 1978" reported by the Committee on Interstate and Foreign Commerce on May 15, 1978 includes authorizations of appropriations for Title XIII of the Public Health Service Act for grants and contracts for feasibility surveys, planning, and initial development costs of $45 million in fiscal year 1979, and for grants and contracts for initial development costs of $50 million in fiscal year 1980. It is the Committee's intent during debate on this measure by the House of Representatives to amend H.R. 12460 to reduce the authorizations of appropriations to $25 million for fiscal year 1979. Authorization of loan guarantee support is extended through September 30, 1979.

This can be compared with the recent budget history of Title XIII:

[In millions of dollars]

Authorizations (fiscal year):	
1974	25.0
1975	55.0
1976	40.0
1977	45.0
1978	45.0
Appropriations (fiscal year):	
1974	25.0
1975	15.0
1976	19.0
1977	18.1
1978	22.1

The Committee has adopted the authorization levels for the next three fiscal years based upon the following HMO activity projected by the Department of Health, Education, and Welfare.

PROJECTED HMO ACTIVITY

[Dollar amounts in thousands]

Grants	Number of grants, 1979	Amount	Number of grants, 1980	Amount	Number of grants, 1981	Amount
Feasibility	70	$5,250	64	$4,800	64	$4,800
Planning	53	10,600	53	10,600	48	9,600
Initial development	5	4,000	48	38,400	48	38,400
Expansion	5	2,500	10	5,000	10	5,000
Technical assistance/training		2,000		4,000		4,000
Total		24,350		62,800		61,800

Assumptions: Feasibility grants will be funded at an average of $75,000—75 percent of these projects will go onto planning stage; planning grants will be funded at an average of $200,000—90 percent of these projects, will go onto initial development; initial development grants will be funded at an average of $800,000—95 percent of these projects will become operational; expansion grants will be funded at an average of $500,000.

Source: Office of Health Maintenance Organization, DHEW.

IV. Background and Need for Legislation

HEALTH MAINTENANCE ORGANIZATIONS

Definition

The term health maintenance organization (HMO) was advanced by Dr. Paul Ellwood in 1970, and was intended to include two basic HMO models: (a) the prepaid group practice model, and (b) the individual practice association or medical care foundation model. In both models, the health maintenance organization receives periodic payments of fixed amounts in return for the services it provides to HMO members. This approach to payment is contrasted to the more common practice where health care providers are reimbursed for each service provided.

Under the group practice model, as the name implies, most medical services are provided by physicians who are members of a group practice. Such physicians may either be employees of the health maintenance organization or be members of a separate entity which contracts with the health maintenance organization to provide medical services to HMO members. Physicians are paid by health maintenance organizations in a variety of ways—the two most common being by salary, or as a group, where the HMO pays the group fixed payments per member each month.

Under the individual practice or medical care foundation model, physicians in a community, generally a county, or group of counties, contract with the health maintenance organization to provide medical services out of their private offices, which can be either solo or group practices. Physicians are generally paid on a modified fee-for-service basis with retrospective adjustments based on performance by the HMO and the individual physicians.

Group practice health maintenance organizations either own their own hospitals, such as is the case for most Kaiser Foundation Health Plans, or arrange for hospitalization for members at one or more community hospitals. The latter arrangement is the most common among group practice HMOs, and is the prevailing practice with individual practice association HMOs.

It has been alleged that a principal difference between health insurance offered by health maintenance organizations and that offered by Blue Cross/Blue Shield and commercial health insurers is that health maintenance organizations either provide or arrange to have provided those services called for in the HMO subscriber contracts, whereas other types of health insurers do not assume this responsibility for their policy holders.

Historical development

Prepaid group practice health maintenance organizations are considered by most historians to have started in the late 1920's and early 1930's. Two were coast physician groups, the Ross-Loos Clinic and the Palo Alto Clinic began offering services on a prepaid basis during that time.[1] In Elk City, Oklahoma, the Community Hospital-Clinic

[1] Somers, Herman M., and Anne Somers. Doctors, Patients, and Health Insurance. The Brookings Institution. Washington, D.C. p. 347.

was started by the Farmer's Union Hospital Association. The consumer cooperative approach to providing for health care in rural communities grew rapidly in the 1930's and 1940's, then virtually disappeared by 1960.[2] * The Kaiser Foundation Health Plans, which are the Nation's largest health maintenance organizations, began as a program for Kaiser industries employees and families, and became a community-wide plan in 1945.[3] The first medical individual practice association, the San Joaquin Medical Care Foundation, was founded in 1954.[4] As of October 1977, there were a total of 168 prepaid plans or health maintenance organizations serving 6.4 million members, according to the Department of Health, Education, and Welfare.[5]

From the inception of group practice prepayment plans, there has been evidence of the medical profession's opposition to these organizations, although such opposition seems to have diminished in recent years. Both Drs. Ross and Loos were expelled from the Los Angeles County Medical Society as a result of their efforts to accept prepayment for medical services, later to be reinstated by the American Medical Association's Judicial Council.[6] In Elk City, Oklahoma, resistance by the local medical society to the efforts of the Community Hospital-Clinic resulted in an out-of-court settlement in 1952 of $300,000 against the local medical society arising from a "restraint of trade" suit.[7] In 1943, the U.S. Supreme Court upheld a verdict of two lower courts that the District of Columbia Medical Society was guilty of restraint of trade activities against the Group Health Association of Washington, D.C.[8] It was also necessary for the State of Washington Supreme Court in 1951 to order the King County Medical Society to stop boycotting the Group Health Cooperative of Washington.[9]

According to a February 1971 article in the Harvard Law Review: [10]

> In late 1970, the AMA warned President Nixon that emphasis on developing prepaid group practice would drive doctors out of active practice, inflate costs, and lower physician productivity. Letter from Dr. Russell Roth, AMA Vice-President, to Roger Egeberg, Assistant Secretary for Health Affairs, HEW, November 30, 1970, quoted in Boston Evening Glove, November 30, at 1, col. 4. The letter concluded "the government should abandon emphasis on pre-paid, comprehensive group practice, although it still may support it.

Subsequent to such communication, however, the American Medical Association stated publicly that it supported a pluralistic approach

---

[2] Ibid., p. 348–349.

*Herman and Anne Somers noted that their decline "appears to lie in a combination of agricultural prosperity, medical society opposition, the availability of Hill-Burton funds, administrative difficulties, and the automobile which reduced the urgent need for local facilities."

[3] Ibid., p. 350.

[4] Egdahl, Richard H., M.D. Foundations for Medical Care. New England Journal of Medicine. v. 288. no. 10. Mar. 8, 1973. p. 491.

[5] Unpublished HMO Program data 1978. Office of Health Maintenance Organizations, U.S. Department of Health, Education, and Welfare.

[6] Somers, Herman M., and Anne Somers. Doctors, Patients, and Health Insurance. The Brookings Institution. Washington, D.C. p. 347.

[7] Ibid., p. 348.

[8] Ibid., p. 349.

[9] Ibid.

[10] Greenberg, Ira G., and Michael L. Rodburg. The Role of Prepaid Group Practice in Relieving the Medical Care Crisis. Harvard Law Review. v. 84. no. 4. Feb. 1971. p. 955.

to the delivery of medical services. However, it urged that the Government consider health maintenance organizations as experimental, and noted: [11]

> * * * that the American Medical Association questions the ability of the HMO to fulfill the public hope for the kind of medical care they want at low cost. We question too that the type of practice offered in the HMO will attract a substantial segment of the medical profession.

There continue to be reports of local resistance to group practice health maintenance organization development. In a recent article in *Medical Care*, Match and Light, in describing efforts to form a group practice health maintenance organization at Long Island Jewish-Hillside Medical Center, noted: [12]

> Actions taken by members of the medical staff to intimidate those who might otherwise have been interested in working for the group far exceeded our expectations and indicate little change in the attitude of the practicing physician in the last decade.

Performance

The following discussion is based upon a review of the existing literature on health maintenance organizations and prepaid group practice and is intended to highlight issues examined by a substantial body of material. It should be noted, however, that while the range of subjects explored in the literature is extensive, the comprehensiveness of this material is limited in nature—for at least two reasons. As several of the topics discussed below indicate, the findings of the literature on HMO's are seldom conclusive. This can in part be explained by the nature of the subject under investigation; there is no one single model for the health maintenance organization or the prepaid group practice. When research is then undertaken to investigate, for example, hospital utilization in the prepaid group practice setting, the findings of such a study for an HMO where physicians are employees of the organization may not be consistent with findings of a similar study where individual practice association HMOs are examined.

In addition, the literature on HMOs is incomplete. As indicated below, sufficient data simply do not exist for several questions to be resolved conclusively. Other subjects, while discussed in general hypothetical terms, have not been tested for validity. More evidence is required to determine just why HMOs have not become a more widespread alternative for the delivery of health care services in the Nation and why they have not been embraced with greater enthusiasm by the public. In the process of answering these questions, topics such as cost of the development of HMOs, availability of managerial talent, public and provider awareness of the HMO alternative, marketing,

[11] Statement by Dr. John R. Kernodle, Vice Chairman, Board of Trustees, American Medical Association. Hearing before the House Subcommittee on Public Health and the Environment of the U.S. House of Representatives' Committee on Interstate and Foreign Commerce on April 13, 1972, on H.R. 5615 and H.R. 11728, Bills to Amend the Public Health Service Act to Provide Assistance and Encouragement for the Establishment and Expansion of Health Maintenance Organizations, and for Other Purposes. p. 337.

[12] Light, Harold L., and Robert K. Match, M.D. The Potential of a Teaching Hospital for the Development of Prepaid Group Practices. Medical Care. v. XIV. no. 8. Aug. 1976. p. 652.

adequate financing and financial planning, and capital availability will have to be examined in greater depth.

Use of hospital services

Published data on health maintenance organizations, in the great majority of instances, show that medical care provided through health maintenance organizations is less costly than under arrangements where health insurers generally pay health care providers fees for services.[13] The cost of care provided to persons eligible for Medicare is less when provided by health maintenance organizations.[14] Studies have also shown that poor people were provided care at less cost when the care was provided by health maintenance organizations.[15] Most experts agree that the major reason for savings achieved by health maintenance organizations results from reduced use of hospital services for HMO members.[16] Reductions in the use of hospitals have most generally been in the range of 20 to 25 percent, although there are a number of reports showing even greater savings reductions in the use of hospital services. Dr. Theodore Cooper, former Assistant Secretary of HEW for Health, stated in November 1975 :[17]

> * * * prototype HMOs surveyed in 1968 demonstrated 53 percent less utilization of inpatient services than traditional health care and that a half dozen newer plans sampled this year showed similar reduction.

Differences in estimates appear to depend to an undetermined extent on whether comparisons are adjusted for such factors as age, and the extent to which HMO members use hospital services outside the HMO plans. In two cases where both factors were taken into account, however, the findings were consistent with those noted earlier. Roemer compared hospital use in prepaid group practice HMOs, persons with commercial insurance, and persons with Blue Cross and Blue Shield coverage. Where the use of hospital services outside the HMO was taken into account, Roemer still found :[18]

> * * * the differential in aggregate hospital days was great—526 days per 1,000 per year in the PGP plans, compared to 864 and 1,109 days in the commercial and provider-sponsored plans, respectively.

Gaus, Cooper, and Hirschman compared hospital utilization using matching groups of beneficiaries of the Aid to Families with Dependent Children and Old Age Assistance categories. They found :[19]

---

[13] Roemer, Milton I., and William Shonick. HMO Performance. The Recent Evidence. Milbank Memorial Fund Quarterly. Health and Society. Summer 1973. p. 272.

[14] Corbin, Mildred, and Aaron Krute. Some Aspects of Medicare Experience with Group Practice Prepayment Plans. Social Security Bulletin. Mar. 1975.

[15] Sparer, Gerald, and Arne Anderson. Utilization and Cost Experience of Low Income Families in Four Prepaid Group Practice Plans. New England Journal of Medicine. July 12, 1973.

[16] Roemer, Milton I., and William Shonick. HMO Performance. The Recent Evidence. Milbank Memorial Fund Quarterly. Health and Society. Summer 1973. p. 272.

[17] Testimony by Dr. Theodore Cooper, Assistant Secretary of Health before the Senate Subcommittee on Health, Committee on Labor and Public Welfare. United States Senate. Nov. 21, 1975.

[18] Roemer, Milton I., and William Shonick. HMO Performance. The Recent Evidence. Milbank Memorial Fund Quarterly. Health and Society. Summer 1973. p. 286–287.

[19] Gaus, Clifton R., Barbara S. Cooper, and Constance G. Hirschman. Contrasts in HMO and Fee-For-Service Performance. Paper presented at the American Economic Association Meetings, Dallas, Texas. Dec. 30, 1975.

* * * hospital use in group practice plans was significantly lower, two and one-half times, than in the fee-for-service system.

ANNUALIZED RATES OF HOSPITAL UTILIZATION

Type of plan	Admissions per 1,000 persons	Average length of stay	Days of hospitalization per 1,000 persons
Group practice	46	7.3	340
Fee for service	114	7.7	888

Data on hospital use by members of individual practice association HMOs is less consistent. Gaus et al., found for example, that there was no statistically significant difference in hospital use between those types of which were studied and the fee-for-service system.[20] Roemer and Shonick cited one study of California State employees which showed that hospital use by members of foundation plans was higher than for all other types of health plans.[21] On the other hand, as the table below indicates, a study of hospital utilization of Federal employees for the period from 1961–1968 showed use by members of individual practice association HMOs to be substantially lower than hospital use for Federal employees and their dependents covered under commercial health insurance or under Blue Cross/Blue Shield.[22]

HOSPITALIZATION EXPERIENCE OF FEDERAL EMPLOYEES

[In days per 1,000 (nonmaternity)]

Plan	1961–62	1968
Blue Cross/Blue Shield	882	924
Indemnity Plan	760	987
Group practice HMO's	460	422
Individual practice HMO's	538	471

The reasons most frequently given as to why hospitalization is reduced are the risk at which HMOs are placed to provide health services for a prospectively determined and fixed capitation payment; the absence of incentives to hospitalize patients because of the way in which physicians in group practice health maintenance organizations are paid (either capitation or salary plus, in some instances, incentive payments) ;* the availability of diagnostic and treatment resources in group practice ambulatory facilities; and restrictions on the numbers of hospital beds available to HMO physicians. Although the latter point is given a great deal of weight by many experts, such a proposition does not explain the low hospital use in health maintenance organizations which do not own or control hospital beds, but use hospital

[20] Ibid.

[21] Roemer, Milton I., and William Shonick. HMO Performance. The Recent Evidence Milbank Memorial Fund Quarterly. Health and Society. Summer 1973. p. 286.

[22] U.S. Department of Health, Education, and Welfare. Bureau of Community Health Services. The Federal Employees Health Benefits Program. Enrollment and Utilization of Health Services—1961–1968. May 1971. Reprinted 1975. p. 11.

*The salary or capitation method of payment is alleged, by HMO proponents, to remove any financial incentive to hospitalize patients.

beds in the community instead. An alternative explanation is that the reliance of prepaid group practices on primary care physicians who do not rely as heavily on highly technological hospitals has an impact on the use of hospitals by group practice physicians. Mason, in his 1970 study of manpower needs by specialty, found prepared group practices relied far more heavily on primary care physician in the fields of internal medicine and pediatrics than did the health services industry as a whole. They also tended to rely less on general surgeons, a factor that may influence the lower number of surgical procedures performed by prepared group practice health maintenance organizations.[23]

Cost

There is fairly broad consensus that care provided through health maintenance organizations is less expensive than that provided through fee-for-service insurance plans. Dr. Theodore Cooper, Assistant Secretary of HEW for Health, noted in November 1975:[24]

> Overall, HMOs appear to achieve cost savings of 10 to 30 percent, compared with traditional health care.

The Roemer et al. California study produced data on the prepaid group practice HMO, as compared with conventional patterns of medical care. (Such costs comparisons commonly combine out-of-pocket expenditures with premiums to obtain the total cost of medical care.) The following table shows one of the findings of the study:[25]

COST COMPARISONS

Plan	Average premium	Out-of-pocket expenditures	Total costs
Commercial insurers	$208	$156	$364
Blue Cross/Blue Shield	257	190	447
Group practice prepayment	271	52	323

The National Advisory Commission on Health Manpower examined health care costs in California in 1965, comparing per capita costs for Kaiser Health Plan members with the per capita costs for all other persons in California. The Commission found:[26]

> Depending upon the figure used on non-Kaiser expenditures on physician services, total Kaiser expenditures are either 55 or 65 percent of the average in the State. Even if allowances for non-comparability raise the Kaiser figure by as much as 25 percent, it would still be only 70–80 percent as large as the State figure.

The Social Security Administration, in a study published by Corbin and Krute, compared per capita Medicare reimbursements made to

[23] Mason, Henry R. Manpower Needs by Specialty. Journal of the American Medical Association. v. 219. no. 12. Mar. 20, 1972.
[24] Testimony by Dr. Theodore Cooper, Assistant Secretary for Health before the Senate Subcommittee on Health, Committee on Labor and Public Welfare. United States Senate. Nov. 21, 1975.
[25] Roemer, Milton I., and William Shonick. HMO Performance. The Recent Evidence. Milbank Memorial Quarterly. Health and Society. Summer 1973. p. 294.
[26] U.S. Department of Health, Education, and Welfare. Excerpts from the Report of the National Advisory Commission on Health Manpower. v. II. Nov. 1967. p. 211.

fee-for-service providers and health maintenance organizations. Seven prepaid group practices were examined. Five of the seven had lower per capita costs than those experienced under the fee-for-service reimbursement system.[27]

Another study sought to evaluate whether Medicaid patients enrolled in a prepaid group practice could receive health care of comparable quality, but at costs lower than that of Medicaid patients receiving health services in the existing fee-for-service program. Fuller, Patera, and Koziol report that under the terms of an experimental contract between the District of Columbia Government and Group Health Association of Washington, D.C. (a prepaid group practice), the voluntary enrollment of 1,000 Medicaid recipients, representing a cross-section of the 160,000 beneficiaries in the Medicaid fee-for-service universe, was authorized in July 1971, and evaluated over a three-year period.[28] Medical services utilization by the 1,000 Medicaid patients was compared for 12 months, 18 months, and 22 months before and after enrollment in the prepaid group practice. Significant and consistent decreases in all four categories of utilization—physician encounters, drug prescriptions, hospital admissions, and hospital days—were found for this group. Overall ambulatory physician encounter rates decreased 15 percent, drug utilization was down 18 percent, hospital admissions decreased 30 percent, and hospital days declined 32 percent after enrollment in the prepaid group practice. For the same benefit package, annual prepaid per capita costs for the 1,000 Medicaid enrollees for 1972, 1973, 1974 were $282, $232, and $286 respectively, representing a 37 percent savings when compared to Medicaid fee-for-service per capita costs of $373, $435, and $465 over the same period.

Preventive care and other ambulatory care services

Studies generally tend to support the frequently made contention that health maintenance organizations provide more preventive services then are provided under other kinds of health insurance. The study by Gaus et al. cited previously, however, found that persons who were not members of a health maintenance organization were more apt to receive preventive services.[29]

Studies have generally shown that a greater percentage of the HMO membership is likely to have some contact with a physician during the course of a year.[30] The data published on the average use of ambulatory services do not show a consistent pattern, however. Studies by Weinerman in California showed that members of the Kaiser Health Plan tended to receive slightly more ambulatory health services than other California residents.[31] Roemer et al. found that HMO members used services slightly more than persons who had commercial health insurance and less than persons with Blue Cross/Blue Shield.[32] The

[27] Corbin, Mildred, and Aaron Krute. Some Aspects of Medicare Experience with Group Practice Prepayment Plans. Social Security Bulletin. Mar. 1975.
[28] Fuller, Norman A., Margaret W. Patera, and Krista Koziol. Medicaid Utilization of Services in a Prepaid Group Practice Health Plan. Medical Care. v. XV. no. 9. Sept. 1977.
[29] Gaus, Clifton R., Barbara S. Cooper, and Constance G. Hirschman. Contrasts in HMO and Fee-For-Service Performance. Paper presented at the American Economic Association Meetings, Dallas, Texas. Dec. 30, 1975. p .16.
[30] Donobedian, Avedis, M.D. An Evaluation of Prepaid Group Practice. Inquiry. 1. VI. no. 3. p. 11.
[31] Roemer, Milton I. and William Shonick. HMO Performance. The Recent Evidence. Milbank Memorial Quarterly. Health and Society. Summer 1973. p. 289.
[32] Ibid., p. 290.

Group Health Cooperative alleges to provide more outpatient services that are provided in the Seattle area generally.[33] Gaus et al. noted that there was little difference in the use of ambulatory services among the Medicaid population which they studied, between persons enrolled in HMOs and those who were not.[34]

Productivity

As noted earlier, the major reason why costs of care provided by health maintenance organizations tends to be lower than cost delivered by fee-for-service providers is the reduced utilization of hospitals by HMOs. Hospital care is the most expensive form of medical care, with the greatest share of our national health expenditures resulting from hospital use. Major reductions appear to be in the number of admissions rather than in lengths of stay of hospitalized patients. Hospital costs incurred for HMO members admitted to hospitals are probably little different than those incurred under the fee-for-service system.

There is little information regarding the productivity of physicians providing care to HMO members and those who do not. The information that is available is often contradictory. Many experts would argue that on theoretical grounds, group practice should be more efficient than solo practice. (Although group practice physicians can either provide care to HMO members or be reimbursed on a fee-for-service basis, group practice health maintenance organizations are the most common form of HMO, while solo practice tends to be more common among fee-for-service physicians.) One of the factors which was identified as an important determinant of physician productivity has been the way in which physicians are paid. According to Roemer, both Kimbell and Lorant and Newhouse found that physicians tended to be more productive when their incomes were more directly related to the number of patients seen than when incomes among physicians are distributed more equally.[35] Kimbell and Lorant, for example, found that physicians using an incentive plan for income distribution had 10 percent greater efficiency than physician groups applying equal sharing or those paid by salaries. HMO proponents commonly advocate that income distribution among group practice physicians should be unrelated to income generated by the individual physicians.

Roemer, however, notes that the common measure of productivity is the numbers of patients seen by physicians. He points out that such a measure does not take into account the content of physician visits. He argues that since prepaid group practices tend to do more on an outpatient basis as an alternative to hospitalization, the inputs related to an outpatient visit in a prepaid group practice must necessarily be greater in enough instances to have an impact on the costs of each outpatient or ambulatory visit.[36]

Impact on health status

Like productivity, there is little data to show whether health maintenance organizations have an impact on the health status of its mem-

---

[33] 1970 Annual Report to the Membership Call to Group Health 1971 Annual Meeting. Mar.–Apr. 1971. p. 4.

[34] Gaus, Clifton R., Barbara S. Cooper, and Constance G. Hirschman. Contrasts in HMO and Fee-For-Service Performance. Paper presented at the American Economic Association Meetings, Dallas, Texas. Dec. 30, 1975. p. 13.

[35] Roemer, Milton I., and William Shonick. HMO Performance. The Recent Evidence. Milbank Memorial Quarterly. Health and Society. Summer 1973. p. 299–301.

[36] Ibid., p. 301.

bers that is significantly different than the impact of fee-for-service providers on the health status of persons they serve. A study done in the 1950's on members of the Health Insurance Plan of Greater New York showed lower rates of premature births and lower rates of perinatal mortality.[37] Recently published studies by Roemer et al. note that there was no significant difference between the perinatal mortality rates of selected individual practice associations in California and those for persons cared for by fee-for-service physicians.[38] Other studies show that HMO members tend to experience less work loss than non-HMO members in the same group of workers.[39] Roemer acknowledges the difficulties in making judgments about such findings because of the difficulties of adequately weighting characteristics of the populations being compared.[40]

Patient attitude

One of the major concerns of both proponents and opponents of health maintenance organizations is patient attitudes regarding health maintenance organizations. A frequently raised criticism of health maintenance organizations is that care provided is impersonal, "clinic" medicine. There is evidence that people do perceive a difference in the way care is provided by group practice health maintenance organizations and by fee-for-service providers. Donabedian noted in his study of patient attitudes:[41]

> It is reasonable to assume, as some studies suggest, that an appreciable proportion of complaints made by subscribers to prepaid group practice plans apply to medical care everywhere. There are, however, certain features of organized group practice that appear to evoke fairly characteristic responses in their subscribers. Freidson points out that prepaid group practice is thought by patients to promote the technical quality of care but to hamper the establishment of a satisfactory personal relationship with the physician. Subscribers seem to think that good quality occurs not because of the superiority of individual physicians in the plan, but through the use of the technical, diagnostic and consultative resources which the plan can muster. Furthermore, subscribers appreciate the absence of financial incentives in the use of these services.

II. Federal Activity Relating to Health Maintenance Organizations

A. BACKGROUND

In September 1959, the Federal Employees Health Benefits Act, P.L. 86–382, was enacted. The law became operational in July 1960. One of its provisions enabled Federal employees to join a comprehen-

[37] Donobedian, Avedis, M.D. An Evaluation of Prepaid Group Practice. Inquiry. v. VI. no. 3. p. 11.
[38] Newport, John, and Milton Roemer. Comparative Perinatal Mortality under Medical Care Foundations and Other Delivery Models. Inquiry. v. XII. no. 1. Mar. 1975.
[39] Roemer, Milton I., and William Shonick. HMO Performance. The Recent Evidence. Milbank Memorian Quarterly. Health and Society. Summer 1973. p. 302–303.
[40] Ibid., p. 302–304.
[41] Donobedian, Avedis, M.D. An Evaluation of Prepaid Group Practice. Inquiry. v. VI. no. 3. p. 8.

sive medical plan as an alternative to joining a medical service plan (Blue Cross/Blue Shield), an indemnity plan (Aetna and other commercial health insurers), or one of the employee organization plans. Comprehensive medical plans were further classified into group practice prepayment plans and individual practice prepayment plans. For 1977, there were 40 comprehensive plans offered to Federal employees. As of June 1977, approximately six percent of all Federal employees and their dependents, a total of 568,000, were enrolled in group practice plans. By far the largest single HMO enroller of Federal employees is the Kaiser Foundation Health Plan; in 1977 nearly 62 percent of all Federal employees and their dependents enrolled in group practice plans were enrolled in Kaiser plans. As of June 30, 1978, approximately 10.5 percent of the Kaiser Health Plan Foundation's subscribers are Federal employees. The HMO most dependent on Federal employees is the Group Health Association of Washington, D.C., with Federal employees comprising approximately 65 percent of its total enrollment of nearly 110,000 persons.[42]

The Social Security Amendments establishing Medicare specifically identified prepaid group practice as a choice available to Medicare beneficiaries. Social Security Amendments in 1968 authorized the Secretary of HEW to finance incentive reimbursement experiments. The House, in its report on the legislation, noted that the Secretary of HEW was authorized to enter into reimbursement experiments with prepaid group practices which would allow hospital costs and physician services costs to be combined into a single payment.[43]

In reviewing the Social Security Amendments of 1965, Secretary of HEW, Wilbur Cohen noted:[44]

> Under Title XIX, Medicaid, each state will administer its own programs, and, eventually, there may be 50 different versions. It is clear, however, that the intent of Title XIX also provided for the payment of services by a capitation arrangement.

The Social Security Amendments of 1972 authorized the Secretary of HEW to establish per capita rates for HMOs combining payments for services under both Parts A and B of the Medicare program. Until the amendments, payments to health maintenance organizations for Parts A and B were made separately.

B. HMO ACT OF 1973, PUBLIC LAW 93–222

Health maintenance organizations became a major health initiative of the Federal Government in 1970, justified principally as a method of cost containment. On February 18, 1971, President Nixon stated in his Health Message to Congress that the Administration proposed to take steps to stimulate the development of health maintenanec organizations. In March of 1971, the Administration introduced its HMO bill to Congress. Congressman William Roy was the principal sponsor

[42] Conversations with Bureau of Retirement, Insurance, and Occupational Health, U.S. Civil Service Commission and Kaiser Foundation Health Plan, San Francisco.
[43] Cohen, Wilbur J. The Development and Future of Group Practice Prepayment Plans. Social Security Bulletin. Jan. 1968. p. 32.
[44] Ibid.

of health maintenance organization legislation in the House of Representatives in 1971. Both bills provided funding to develop new health maintenance organizations and expand existing ones, as well as including other measures to encourage HMO development and third-party payer acceptance. Hearings were held on the legislation during the 92nd Congress, by the House Subcommittee on Public Health and the Environment of the Interstate and Foreign Commerce Committee. The full Committee's bill was not reported out during the session. A more extensive health maintenance organization bill was introduced by Senator Kennedy in the Senate. The bill, which included both developmental moneys for HMOs and payments to HMOs to care for the poor was passed by the Senate during the 92nd Congress.

The legislation was reintroduced in both the House and the Senate during the 93rd Congress, subsequently becoming law in December 1973, as the Health Maintenance Organization Act of 1973, Public Law 93–222.

Major features of the law included requirements that federally qualified HMOs must: (a) offer those health services specified in the HMO Act, (b) hold an annual 30-day open enrollment period when persons could join the HMO on a first-come, first-served basis, and (c) establish their premiums on a community-rated basis with the exception of those for Medicare and Medicaid eligibles.

The Act authorizes $325 million in grants and loans for HMO development. Two hundred and fifty million dollars was authorized for grants for feasibility studies, and for the planning and development of HMOs, and $75 million was authorized to capitalize a loan fund to provide loans to cover early operating deficits of HMOs.

Progress in implementing the Act was less than had been contemplated under the HMO Act of 1973. When the health maintenance organization strategy was first announced by the Administration, it called for the development of 1,800 health maintenance organizations. The intention of the Congress in passing the legislation appeared to be considerably less ambitious. The House Committee on Interstate and Foreign Commerce, in its report on the legislation, noted that the Act should provide sufficient funding for 100 new health maintenance organizations.

C. IMPLEMENTATION—GAO REVIEW 1975

The General Accounting Office (GAO) reviewed the implementation of the HMO Act of 1973 by HEW. In its testimony before the Subcommittee on Health of the Senate Labor and Public Welfare Committee, a GAO representative stated: [45]

> Slow progress in implementation of the HMO program is evident in that HEW has not used over $17.5 million of the $40 million in grant funds which were available for fiscal years 1974 and 1975. Further, the Administration has requested only $15 million of the $85 million authorized for grants in fiscal year 1976.

[45] Testimony by James D. Martin, Deputy Director, Manpower and Welfare Division before the Senate Subcommittee on Health, Committee on Labor and Public Welfare. United States Senate. Nov. 21, 1975.

The following reasons were given for the slowness in implementing the HMO Act:

(*a*) Failure to publish regulations in a timely manner, noting that regulations on all aspects of the program had not been implemented almost two years after the passage of the Act;

(*b*) Underfinancing of the HMO program, citing data showing projects that could not be funded because of the lack of funds,

(*c*) Poor organization of HEW efforts, noting that responsibility for implementation was widely scattered throughout the Department of HEW; and

(*d*) Insufficient number of persons with the necessary skills to assist in devoleping health maintenance organizations.

One of the reasons given for failure to implement the Act as rapidly as had been expected was the alleged flaws in the Act, which critics contended discouraged applications for financial support.

The criticisms of the Act centered primarily on the following:

(*a*) The health services required to be offered were too extensive, causing extraordinary efforts to make all the services required available and making the benefit package so costly that employers and unions could not afford to purchase it.

(*b*) The requirement that HMOs must have an annual open enrollment period on a first-come first-served basis would make HMOs vulnerable to adverse selection, where very sick persons who could not obtain health insurance elsewhere would join HMOs. The impact, again, would be to raise the cost of care to all members and make HMOs non-competitive.

(*c*) The requirement that the HMO must establish rates based on the costs to provide care to all its members, rather than to develop rates based on the cost experience of different employer and other groups, was contrary to established practice in some communities and, again, caused marketing problems for some HMOs.

(*d*) Unions were opposed to the so-called dual choice provisions of the HMO Act as interfering with their collective bargaining rights. Under the dual choice arrangement, employers with 25 or more employees in the previous calendar quarter, and subject to section 6 of the Fair Labor Standards Act of 1938, would be required to offer their employees the option of joining at least one qualified group practice HMO and one qualified individual practice HMO, if the employees were within the service area of both types of HMOs. Unions argued that any determination as to health plans to be offered to employees where the union was the collective bargaining agent should be a matter between the union and the employer.[46]

D. HEALTH MAINTENANCE ORGANIZATION AMENDMENTS OF 1976

During 1975, Congressman James Hastings and Senator Richard Schweiker introduced identical bills to amend the HMO Act, which responded to all of the objections noted above. The Health Maintenance Organization Amendments of 1976, which was signed into law on

[46] Business Week. The HMO Movement Stalls Once More. Apr. 21, 1975.

October 8, 1976, is similar to the bills that were introduced by Congressman Hastings and Senator Schweiker.

The Amendments reduced the services that HMOs are required to offer, and amended the open enrollment provisions by exempting HMOs from the open enrollment provision until they have enrolled 50,000 members or until they have been in operation for five years, whichever occurs first. They also provided a grace period of four years during which established health maintenance organizations can switch their method of establishing premiums from the experience to the community rating method. They provided that the collective bargaining agents for employee groups must first determine whether a qualified health maintenance organization can be offered to a group of employees before other requirements for an employer offering its employees the HMO option or options would apply.

The Amendments changed the requirements for medical group practices, including a provision that medical groups would be required to provide at least 35 percent of their services, rather than a majority of their services, to HMO members. The new Act amended the Social Security Act to make the definitions under both Titles XVIII and XIX of the Social Security Act more consistent with the definition of an HMO under the Act, as amended.

Other changes in the HMO law included those relating to the greater consolidation of Federal HMO program activities, program evaluation, enforcement of the Act's provisions, HMO development in nonmetropolitan areas, and certain exemptions to the dual choice provisions of the Act. The Amendments increased the amounts of funds available for individual feasibility studies from $50 thousand to $75 thousand, from $125 thousand to $200 thousand for individual planning projects, and from $1.0 to $1.6 million for individual projects to expand existing health maintenance organizations.

The Amendments extended the HMO program for two aditional years through fiscal year 1979, authorizing grants of $45 million for fiscal year 1978, and $50 million for fiscal year 1979 (FY 79 authorizations are for initial development grants only). No loans can be made or guaranteed after September 30, 1980.

E. GAO REPORT 1978

In 1978 GAO again reviewed the implementation of the HMO Act, as amended. The GAO report, issued on June 30, 1978, reviewed 14 HMOs out of the 27 HMOs that had been qualified by the Department of Health, Education, and Welfare. The General Accounting Office made the following findings:

A. *Have HMOs been able to comply with requirements for providing health services?* Qualified HMOs must provide health services in the manner prescribed by section 1301(b) of the HMO Act. The HMOs evaluated by GAO were found generally to be providing health services in the required manner. However, the following exceptions were noted:

HEW has not issued guidelines for establishing rate structures; therefore GAO could not conclusively determine HMOs' compliance with the community rating requirement.

Some HMOs have two and three step rate structures under which the rates for couples do not appear to be equivalent.

Although the Act no longer required children's preventive dental care or supplemental services, these HMOs generally have retained such services.

Although HMOs may now use any combination of staff or group health professionals as long as 35 percent of the hired medical groups professional activity is devoted to serving HMO members, these HMOs have not changed their modes of operation.

B. *Have HMOs been able to comply with the Act's organizational and operational requirements?* Section 1301(c) of the HMO Act prescribes how HMOs must be organized and operated. The HMOs evaluated generally were organized and operated in the manner described by the Act except for the following:

Mainly because of problems in contracting with HEW and States to serve Medicare and Medicaid recipients, HMOs generally have enrolled few elderly or indigent persons.

Although several of the 14 HMOs should have held 30-day open enrollment periods under the original Act, none did. None of the 14 HMOs is yet required to offer open enrollment under the Act, as amended, and none definitely plans to offer open enrollment until it is required. Consequently, high-risk individuals have not had ready access to membership in these organizations.

Some HMOs have enrolled persons from medically underserved areas in the course of marketing to employee groups, but HMOs have not specifically directed their services to medically underserved areas.

C. *Can HMOs operate without continued Federal financial assistance?* The HMO Act, as amended, envisions qualified HMOs as financially sound business enterprises which can operate independently—without Federal financial assistance—after their first five years of operation as a qualified HMO. Of the 14 HMOs evaluated, GAO concluded that:

Three HMOs have a good chance of achieving financial independence within five years;

Five HMOs have a fair chance; and

Six have a poor chance.

The GAO reached some general conclusions about the factors which affect the ability of HMOs to become self-sustaining business entities.

HMOs which depend heavily on health care resources in the fee-for-service sector lack control over a significant portion of their costs. HMOs may control their utilization of these resources, but do not control managers in the fee-for-service sector who make decisions affecting cost, efficiency, and effectiveness.

On HMO's pricing strategy is as important as cost control. Consistently underpricing services to be competitive may be expedient in the short term but can lead to difficulties in the long term. In the short term, an HMO generally should be able

to establish subscriber rates which will generate at least enough revenue per member to cover variable costs. If because of competitive pressures an HMO cannot establish rates which will cover variable costs, the HMO may eventually face a gap between revenues and costs so large that it cannot increase its rates enough to close the gap and break even.

Effective management is critical for an HMO's success. As an independent enterprise, an HMO must be able to adequately control costs and utilization, budget and plan for the future, and market its services. Federal loans should not be used to subsidize poor management but to establish well-planned, well-managed business entities. Properly trained managers are needed.

Although third-party relationships may aid HMOs, the relationships may present possibilties for abuse which could harm an HMO's financial soundness. The potential for minimizing adverse effects of third-party relationships on an HMO's operations exists through public disclosure.

D. *What is the Effect of Dual Choice on Employers?* Section 1310 of the HMO Act, as amended, requires certain employers to offer their employees the option of enrolling in a qualified HMO. To determine the effect of this dual choice requirement, GAO interviewed 247 employers, 187 of whom were offering dual choice. They also contacted officials of 20 local unions to determine their views toward the HMO concept or the Act. From statements made during these interviews, GAO concluded that the dual choice requirement has not had a significant effect on employers' costs. HMO's have not emphasized the dual choice requirement in marketing their plans, and unions generally have reacted favorabliy toward HMO's.

E. *Quality Assurance Programs*—Section 1301(c)(8) of the Act requires HMO's to have organizational arrangements for an ongoing program to assure the quality of health services. The HMO's evaluated by GAO had been certified by HEW as meeting the requirements of the Act and regulations; however, during the evaluations, GAO noted that:

Quality assurance programs varied among HMOs.

HMOs' quality assurance programs were not necessarily in place when they began operating as qualified HMOs.

Standards for quality assurance programs were still in the development stage.

F. *Review of Items Discussed in September 1976 report*—In September 1976, GAO reported that several aspects of HEW's implementation of the HMO Act had hampered program development. The problems included (1) fragmented responsibility and uncoordinated efforts in implementing the program, (2) not enough staff with needed expertise to administer the program effectively, and (3) slow issuance of final regulations and guidelines for implementing and enforcing the Act. In reviewing these findings GAO reported that:

HEW has taken some steps to deal with HMO program management problems. However, most of the actions are

either too recent to gauge their effectiveness or not comprehensive enough to correct the problems. That is, HEW has (1) centralized the headquarters program under a newly appointed director but has not resolved the question of regional staff use, (2) allocated new positions to the qualification and compliance office which is understaffed but no new positions were allocated to the loan branch which, we believe also is understaffed, and (3) issued interim regulations to implement the 1976 amendments but has not issued final regulations and guidelines defining requirements for HMOS.

TITLE XIII—HMO ACT BUDGET HISTORY

[In thousands]

	1974	1975	1976 [1]	1977	1978 estimate	1979 estimate
Authorized:						
Grants/contracts	$25,000	$55,000	$40,000	$45,000	$45,000	$50,000
Loans	75,000					
Appropriations:						
Grants/contracts	25,000	15,000	19,043	18,100	21,100	25,910
Carryover			[2] 727			
Loans	[3] 35,000					
Program support	700	4,040	4,980	4,681	5,120	6,297
Total available	60,700	19,040	24,750	22,781	26,220	32,207
Obligations:						
Grants		23,168	18,248	17,125	19,100	25,910
Unused nonmetropolitan set-aside		727	1,241	975	0	0
Program support		3,658	4,959	4,649	[4] 7,120	6,297
Q & C	([5])	([6])	(293)	(772)	(874)	(2,207)
Lapsed (program support)		1,082	21	32		0
Reprogramed out to grant funds		15,943	0	0	[4] (2,000)	0
Lapsed grant funds		162	281	0	0	0
Total		44,740	24,750	22,781	26,220	32,207

[1] Includes transition quarter.
[2] Nonmetropolitan rural set-aside funds from previous year.
[3] The loan and loan guarantee fund is a revolving account and is replenished by selling notes to the Federal financing bank.
[4] Includes $2,000,000 reprogramed from grant funds: $250,000 for additional 37 positions; $1,750,000 for technical assistance contracts.
[5] Obligations, except for program support, all occurred in 1975 but were charged against both 1974 and 1975.
[6] Not identifiable in program support.

III. Prepaid Health Plans in California

Prepaid health plans which have been described as a form of health maintenance organization, have received national attention during the last several years. Senator Henry Jackson, Chairman of the Permanent Subcommittee on Investigations of the Senate Governmental Affairs Committee saw the problems arising in California relating to prepaid health plans as important in formulating any program of national health insurance. His Subcommittee held hearings in March 1975 and December 1976 for the purpose of examining prepaid health plans. A brief review of the prepaid health plan development in California follows.

The Medi-Cal Reform Act, passed by California in 1971, provided for contracting with groups of medical providers to supply services on a prepaid basis to Medicaid recipients. The law stipulted that Prepaid Health Plans (PHPs) would provide or arrange for health care

services for persons eligible for California's public assistance programs and who voluntarily enroll in PHPs. In turn, the State would pay PHPs a fixed monthly premium per enrollee for providng health care services.

The California legislature consolidated all prepaid health related statutes into a new chapter of the State's Welfare and Institutions Code by enacting the Waxman-Duffy Prepaid Health Plan Act, effective July 1, 1973. The Waxman-Duffy Act defined a PHP as:

> * * * any carrier or association of providers of medical and health services who agree with the (California) Department of Health to furnish directly or indirectly health services to (Medicaid) beneficiaries on a predetermined periodic rate basis.

According to a GAO report:

> There are three types of prepaid health plans in California. One is the self-contained plan in which all of the physicians' providers are salaried employees of the plan, and the plan owns and operates most facilities in which health care is provided. Another is the clinic type in which one or more clinics are operated by a group of physicians and specialty services are provided through fee-for-service subcontracts with health care providers. The third type is the foundation plan in which the prepaid plans pays its providers on a fee-for-service basis. The fees paid to the providers are established by the foundation, which acts as a fiscal intermediary receiving capitation payments from the State agency and disbursing the monies to health care providers.

The legislature's intent in creating PHPs, as defined in the Waxman-Duffy Act, was to:

(1) encourage the development of more efficient delivery of health care to Medicaid recipients;

(2) reduce the inflationary costs of health care;

(3) improve the quality of medical services to eligible enrollees, and

(4) reduce the administrative costs of operating Medicaid.

Since its inception, the PHP program has been the subject of considerable controversy. Reports criticizing PHPs and the State of California's administration of the PHP program have included those by the California State Auditor General, the General Accounting Office, and the Senate Subcommittee on Investigations of the Committee on Governmental Affairs.

The Auditor General's report was transmitted to the State Legislature in April of 1974.[47] He found that of the payments made by the PHPs, only 48 percent was for health care services and the balance was for administrative costs or for profits. The following is a summary of his findings:

> Of the $56.5 million payments made by the Department of Health to 15 Prepaid Health Plan (PHP) contractors,

[47] U.S. Congress. Senate. Permanent Subcommittee on Investigations of the Committee on Government Operations. Prepaid Health Plans. Hearings. 94th Congress. 1st Session. Mar. 13–14, 1975. Washington.-U.S. Govt. Print. Off. 1975. p. 292, 296.

only an estimated $27.1 million, or 48 percent, was expended for health care services for Medi-Cal recipients. The balance of $29.4 million of the Department of Health payments, or 52 percent of such payments, was expended by the PHP contractors for administrative costs or resulted in net profits.

The Department of Health has not properly discharged its statutory authority and responsibility to institute and require uniform accounting procedures, complete financial reporting and routine auditing of PHP contractors and their affiliated subcontractors.

The report also analyzed the prevailing organizational practices among Prepaid Health Plans and found non-profit organizations contracting with for-profit organizations. This practice is said to create a strong appearance of improper self-dealing.

The Department of Health has contracted for the operation of PHPs primarily with nonprofit corporations. All of the 15 PHPs we reviewed except two were organized as nonprofit corporations. One of these two, Americare, was originally organized as a profit-making corporation but at the department's insistence has since reorganized into a nonprofit corporation. The other PHP contractor, South Bay Family Medical Group, Incorporated, is still organized as a profit-making corporation but has not enrolled any prepaid recipients.

The officers or directors of eight of the PHPs we reviewed had formed profit-making partnerships, associations and corporations which supply various services to the nonprofit PHP contractors.

Through these affiliated profit-making subcontractors, the officers and directors of the nonprofit PHP contractors are able to obtain profits from what is ostensibly a nonprofit operation. Also, the complex relationship created by the use of these interlocking firms makes it more difficult to determine how much of the Department of Health's payments to the PHP contractors actually is expended for health care services for Medi-Cal recipients and how much results in net profits or is expended on executive salaries and other costs of administration.

The Auditor General found their administrative costs, including profits, ranged from 24 to 93 percent of total revenues received through prepaid health plan contracts with the State.

The General Accounting Office has published a number of reports regarding Prepaid Health Plans in California. The first report, published in September 1974, included the following findings: [48]

(1) In many instances, the State of California was paying PHPs more per capita than they were paying fee-for-service providers;

[48] U.S. Government Accounting Office. Report to the Committee on Finance. United States Senate. Better Controls Needed for Health Maintenance Organizations under Medicaid in California. B–164031(3). Sept. 10, 1974.

(2) Many of the PHPs were engaging in irregular enrollment practices, including door-to-door solicitation, resulting in large numbers of beneficiary grievances and disenrollments from PHPs (there was a 3.1 percent recipient turnover); and

(3) The State of California had not developed adequate criteria for assessing the quality of care provided to PHP enrollees.

A later GAO report dated August 1975 found that:[49]

(1) Rate-setting procedures did not take into account differences in the need for and use of health services between the prepaid health plan enrollees and the Medicaid fee-for-service population.

(2) One prepaid health plan was paid $4.6 million more than estimated fee-for-services costs without an accompanying State justification for the higher payment, even though Federal and State regulations prohibit paying more to prepaid plans than the services would cost under the fee-for-service system.

(3) The State of California made an estimated $4.2 million in duplicate payments under the fee-for-service system for health services prepaid plans were obligated to provide.

The General Accounting Office recommendations arising from the two reports included those to HEW to prepare regulations:

(1) providing guidance to the States in monitoring the quality of health care provided to PHP Medicaid enrollees;

(2) establishing procedures for controlling and monitoring enrollment and disenrollment;

(3) requiring that the States insure that all PHPs have grievance procedures; and

(4) establishing procedures relating to rate setting.

In April 1978 the Permanent Subcommittee on Investigations of the Senate Committee on Governmental Affairs issued a report based upon the record developed during the March 1975 and December 1976 hearings and an investigation of program reform efforts.[50] The report summarizes information obtained by the Subcommittee evidencing: fraud and abuse of the California Prepaid Health Plan program; failures by the State government in program management; inadequacies in Federal oversight of the California program; and questions concerning the adequacy of the present Federal program to encourage the development of health maintenance organizations across the Nation.

The report cited a statement from the September 1974 GAO report that there is "no assurance that the PHP program is achieving its objective of reducing Medicaid costs and may be more costly than the fee-for-service programs". The Subcommittee indicated its feeling that this may still be true.

The Subcommittee inquiry found that almost all of the 54 California

---

[49] U.S. Government Accounting Office. Report to the Committee on Finance. United States Senate. Deficiencies in Determining Payments to Prepaid Health Plans under California's Medicaid Program. B–164031(3). Aug. 29, 1975.

[50] U.S. Congress. Senate. Permanent Subcommittee on Investigations of the Committee on Governmental Affairs. Prepaid Health Plans and Health Maintenance Organizations. Senate Report No. 95–749; 95th Congress. 2d session. Apr. 20, 1978.

prepaid health plans reviewed by the Subcommittee were non-profit, tax-exempt organizations that subcontracted with for-profit organizations owned or controlled by officers or directors of the non-profit organizations. The inquiry showed that this type of corporate structure and contracting practice opened the way for the diversion of Medicaid funds away from the program's purposes.

The Subcommittee inquiry also found that consultants served as brokers, promoting State contracts for interested entrepreneurs in return for a percentage of Medicaid program payments made under State contracts. The money to finance these contracts often came from the poor who were enrolled in prepaid health plans by door-to-door salesmen employed by the plans, some of whom coerced the enrollment of Medicaid beneficiaries.

The Subcommittee reported that the quality of the health care was often found to be poor and even dangerous by State medical auditors. Services were sometimes provided through non-accredited and substandard hospitals. State program managers ignored these reports as well as findings of the State's own fraud investigators, legislative hearings, audits and exposes in the press. The State's failure to respond to compelling evidence of fraud and abuse was seen as part of the government mismanagement of the Medi-Cal program.

Although Prepaid Health Plans are frequently compared with health maintenance organizations, PHPs have not conformed to all elements of the definition of HMOs contained in the Health Maintenance Organization Act, P. L. 93–222, nor were they required to do so. Under the Health Maintenance Organiaztion Act amendments, however, plans contracting with the State of California, in most instances, would have to meet the definitions of an HMO contained in the HMO Act, as amended. Exceptions to this requirement would be where Title XIX statutory requirements might conflict with the amended HMO Act.

According to HEW officials, many of the PHPs which had contracted with the State of California to provide care to Title XIX beneficiaries did not continue to qualify as contractors because of the new requirements imposed by amendments to the Health Maintenance Organization Act. As of January 1977 there were 26 plans serving roughly 191,000 persons. As of April 1978 there are 13 plans contracting with the State to provide Medicaid services. These plans serve approximately 125,000 persons. Of these 13 plans, eight are qualified HMO's and serve 96,000 persons. (One of the plans serves 50,000 persons.) Of the remaining five plans, five are exempt from the Act because of their previous status as community health centers and one is provisionally qualified. There is no available information on the 13 plans that existed prior to the amendments and did not become qualified or gain "exempt" status, but it is believed that most are out of business.[51]

[51] Conversation with Ms. Nancy McMann, Medicaid Bureau on July 31, 1978.

Legislative History

chronology of events

92d Cong.

Date	*Events*
Feb. 18, 1971	Presidents' 1st health message to Congress advocates Federal assistance to HMO's (H. Doc. No. 92–49).
Do	S. 837, the Local Comprehensive Health Service Systems Act of 171, is introduced by Senator Javits.
Mar. 4, 1971	H.R. 5615, the Health Maintenance Organization Assistance Act of 1971, is introduced by Mr. Staggers and Mr. Springer (original administration bill).
Mar. 10, 1971	S. 1182, identical to H.R. 5615, is introduced by Mr. Javits, and Messrs. Baker, Beall, Bellmon, Case, Cooper, Dole, Dominick, Fannin, Fong, Griffin, Jordan of Idaho, Mathias, Percy, Prouty, Saxbe, Scott, Stevens, Taft, Weicker, Young, Hruska, Pearson, and Boggs.
Nov. 11, 1971	H.R. 11728, the Health Maintenance Organization Act of 1971, is introduced by Mr. Roy, Mr. Rogers, Mr. Kyros, Mr. Preyer, Mr. Symington, Mr. Nelson, Mr. Carter, and Mr. Hastings.
Mar. 2, 1972	President's 2d health message to Congress again advocates HMO's. (H. Doc. No. 92–261).
Mar. 13, 1972	S. 3327, the Health Maintenance Organization and Resources Development Act of 1972, is introduced by Mr. Kennedy, Mr. Javits, Mr. Magnuson, Mr. Cranston, Mr. Eagleton, Mr. Hughes, Mr. Mondale, and Mr. Stevenson.
July 21, 1972	S. 3327 is reported from the Committee on Labor and Public Welfare (S. Rept. No. 92–978).
Sept. 20, 1972	S. 3327 passes Senate by a vote of 60 to 14.
Sept. 21, 1972	H.R. 16782, the Health Maintenance Organization Act of 1972, a clean, markedup successor to H.R. 11728, is introduced by Mr. Roy, Mr. Rogers, Mr. Kyros, Mr. Preyer, Mr. Symington, Mr. Nelson, and Mr. Carter.
Jan. 3, 1973	H.R. 51, the Health Maintenance Organization Act of 1973, is introduced by Mr. Roy, Mr. Rogers, Mr. Kyros, Mr. Preyer, Mr. Symington, and Mr. Hastings, (identical to H.R. 16782).
Jan. 4, 1973	S. 14, the Health Maintenance Organization and Resources Development Act of 1973, is introduced by Mr. Kennedy and others (identical to S. 3327, as passed).
Feb. 22, 1973	S. 972, the Health Maintenance Organization Assistance Act of 1973, is introduced by Mr. Javits and Mr. Schweiker (2d administration bill).
Feb. 27, 1973	H.R. 4871 is introduced by Mr. Staggers and Mr. Devine (identical to S. 972).
Apr. 27, 1973	S. 14 is reported from the Committee on Labor and Public Welfare (S. Rept. No. 93–129).
May 9, 1973	Amendment No. 122 to S. 14 is introduced by Senators Javits and Schweiker.
May 14, 1973	Amendment in the nature of a substitute introduced by Senator Kennedy, and adopted.
May 15, 1973	S. 14 passes the Senate by a vote of 69 to 25.
May 21, 1973	H.R. 7974, a clean, marked-up successor to H.R. 51, is introduced by Mr. Roy, Mr. Rogers, Mr. Kyros, Mr. Preyer, Mr. Symington, Mr. Nelson, Mr. Carter, Mr. Hastings, Mr. Heinz, and Mr. Hudnut.

LEGISLATIVE HISTORY—Continued

CHRONOLOGY OF EVENTS—continued

Date	Events
	93d Cong.
Aug. 10, 1973	H.R. 7974 is reported from the Committee on Interstate and Foreign Commerce (H. Rept. No. 93–451).
Sept. 12, 1973	H.R. 7974 passes House by a vote of 369 to 40. S. 14 passes House, amended to contain the language of H.R. 7974, as passed.
Dec. 18, 1973	House agrees to conference report on S. 14 by a voice vote (H. Rept. No. 93–714).
Dec. 19, 1973	Senate agrees to conference report on S. 14 by a vote of 83 to 1 (S. Rept. No. 93–621).
Dec. 29, 1973	S. 14 is signed by President (Public Law 93–222).
	94th Cong.
June 12, 1975	S. 1926, the Health Maintenance Organization Amendments of 1975 is introduced by Mr. Schweiker, Mr. Mondale, and Mr. Javits.
	H.R. 7847 (identical to S. 1926) is introduced by Mr. Hastings and Mr. Rogers.
July 29, 1975	H.R. 9019, a clean marked-up version of H.R. 7847, is introduced by Mr. Hastings, Mr. Rogers, and Messrs. Preyer, Symington, Scheuer, Florio, Carney, Broyhill, and Heinz.
Sept. 26, 1975	H.R. 9019 is reported from the Committee on Interstate and Foreign Commerce (H. Rept. 94–518).
Nov. 7, 1975	H.R. 9019 passes the House by a vote of 309 yeas to 45 nays.
May 13, 1976	S. 1926 is reported from the Committee on Labor and Public Welfare (S. Rept. 94–844).
June 14, 1976	H.R. 9019 passes the Senate, amended to contain the language of S. 1926, as amended, by a vote of 80 yeas to 8 nays.
Sept. 16, 1976	Senate agrees to the conference report on H.R. 9019 (H. Rept. 94–1513).
Sept. 23, 1976	House agrees to conference report on H.R. 9019.
Oct. 8, 1976	H.R. 9019 is signed by President Ford (Public Law 94–460).
	95th Cong.
Feb. 10, 1978	S. 2534, the Health Maintenance Organization Amendments of 1978 is introduced by Mr. Schweiker, Mr. Kennedy, Mr. Williams, Mr. Javits, Mr. Pell, and Mr. Chafee.
May 15, 1978	S. 2534 is reported from the Committee on Human Resources (S. Rept. 95–837).
June 22, 1978	H.R. 13266, the Health Maintenance Organization Amendments of 1978 is introduced by Mr. Rogers.
July 21, 1978	S. 2534 passes the Senate by a vote of 71 yeas to 1 nay.
July 31, 1978	H.R. 13655, a clean marked-up version of H.R. 13266 is introduced by Mr. Rogers, and Messrs. Preyer, Scheuer, Waxman, Florio, Maguire, Markey, Ottinger, Walgren, Carter, Broyhill, and Skubitz.
Aug. 11, 1978	H.R. 13655 is reported from the Committee on Interstate and Foreign Commerce.

B. HISTORY OF MAJOR LEGISLATIVE ISSUES

With the introduction in the 92nd Congress of legislation which would provide Federal support for the development and operation of health maintenance organizations, a variety of approaches and diverse

points of view were expressed in proposals outlining the form and content which a Federal program should assume. The following discussion enumerates many of the legislative issues arising from these different approaches and provides background on their development during the consideration of enabling legislation in the 92nd and 93rd sessions of Congress and amending legislation in the 94th Congress. Finally, the discussion details the resolution of these issues in public law.

Benefit package.—The Public Health Service Act requires a Federally qualified HMO to provide each enrollee with a specific range of basic health benefits in return for a fixed, monthly payment. In addition, HMO's are permitted to offer enrollees optional health benefits for added monthly payments which are also fixed. Determination of the range and structure of basic and optional services to be offered remained a controversial issue throughout the early development of Federal HMO legislation. During the 92nd and 93rd Congresses, House and Senate advocates of HMO's consistently supported different versions of the basic and optional benefit package. S. 3327, representing the position of certain members of the Committee on Labor and Public Welfare during the 92nd Congress, requiring HMO's to offer a basic benefit package that was considerably broader than the basic package required by H.R. 16782, a bill sponsored by certain members of the Committee on Interstate and Foreign Commerce during the 92nd Congress. Subsequent versions of House and Senate legislation on HMO's in the 93rd Congress (H.R. 51, 7974, S. 14) retained these differences. A compromise on these issues was not achieved until the legislation went to conference in 1973.

Both the House and Senate bills required HMO's to provide the following basic services: physician's services, inpatient and outpatient hospital services, home health services, diagnostic laboratory and diagnostic and therapeutic radiologic services, emergency health services, vision care (the House bill limited this to children's eye examination's) and preventive health services. Additional basic services required by the Senate bill were: provision of or payment for prescription drugs; medical social services; physical medicine and rehabilitative services, mental health services, preventive treatment for alcohol and drug abuse and addiction, and other personal care services the Secretary of HEW felt necessary to maintain health. The Senate bill permitted the HMO to phase-in specific comprehensive health services over a three year period if health manpower needed to provide the service was unavailable.

Both House and Senate bills also required HMO's to make specific optional services available to all enrollees, if the enrollees requested the service and paid an additional monthly payment. However, the House bill qualified this requirement by permitting HMO's to furnish only those optional services that could be made reasonably available to its membership. A number of the required basic services under the Senate bill were optional under the House bill. Optional services under the House bill were: long-term care facility services, dental services (other than preventive dental care for children which was a required preventive health service), mental health services, vision care (other than children's eye examination which was a required preventive

32-310 O - 78 - 3

service), physical medicine and rehabilitative services, and prescription drugs. Optional services under the Senate bill were limited to skilled nursing facility care and dental services.

The 1973 conference agreement on the benefit package generally conformed to the House bill. The House version of the basic benefit package, called "basic health services" was expanded to include mental health services (limited to 20 visits) and alcohol and drug abuse and addiction services. The House version of the optional benefit package, termed "supplemental health services," was also adopted (with certain modifications).

It should be noted that during the 92nd Congress, two HMO bills were advocated by certain members of the Committee on Interstate and Foreign Commerce. H.R. 11728, the precursor of H.R. 16782, contained a broader benefit package than the second bill. The original House bill required HMO's to offer all the basic services required under H.R. 16782, plus nursing home care, rehabilitative medicine, and other personal health care services determined necessary by the Secretary of HEW. It did not require HMO's to make optional services available to enrollees; however, HMO's were permitted to offer a broader range of health services than required.

During the 94th Congress debate on the HMO Amendments of 1976, issues related to the HMO benefit package did not evoke the controversy of earlier Congresses. Major House and Senate amendments to the benefit structure were essentially similar (contained in H.R. 9019 as reported, and S. 1926, as reported, 94th Congress) and were aimed at reducing the scope of benefits which the HMO was required to have the capacity to provide. They were intended to decrease total costs of an HMO's benefits package to enable the HMO to compete more effectively for membership. Both bills permitted an HMO to make supplemental health services available at the HMO's option rather than upon the enrollee's request. HMO's would no longer be required to maintain the capacity to supply the full range of supplemental health services.

There were several differences, however, in certain House and Senate provisions relating to the HMO benefit structure. One House provision, adopted in Conference, permitted HMO's to integrate supplemental health services into the basic benefit package which enrollees are required to purchase for a basic health services payment. Another House provision, not adopted in Conference, aimed to make alcohol and drug abuse and addiction services a supplemental rather than basic service. Both bills made similar changes in the definition of required preventive health services; the House bill, however, added a provision (accepted in conference) which made children's ear examinations a required preventive health service.

Copayments.—Copayments are small individual charges for specific services which are paid by the HMO enrollee in addition to the basic health service payment. Generally, copayments are levied by the HMO at the time the service is provided. For example, an enrollee might be charged $1 for each visit to a physican. Copayments are an additional source of funding for an HMO.

The issue of whether a Federally qualified HMO should be permitted to charge copayments for specific basic health services was

another source of controversy during the development of HMO legislation in the 92nd and 93rd Congresses. S. 3327, as introduced in the 92nd Congress (and all subsequent versions of this HMO legislation in the 92nd and 93rd Congresses), did not permit the use of copayments. House HMO legislation during the 92nd and 93rd Congresses (beginning with H.R. 11728 and all subsequent versions) allowed HMO's to charge nominal copayments for specific services within the basic health service benefit package. The copayment amount was to be fixed in accord with DHEW regulations.

Senate advocates of HMO legislation were opposed to the use of copayments because they believed that these additional charges might discourage some enrollees from seeking needed care. House advocates, with similar concerns, specified that the copayment amount was to be truly nominal. They believed, however, that copayments should be permitted as one mechanism to offset total costs of the basic health services package.

The conference agreement on the 1973 HMO legislation substantially conformed to the House provision. Federally qualified HMO's would be permitted to charge their enrollees additional nominal copayments for specific basic health services as long as such payments did not act as a barrier to the delivery of the services. The copayment amount was to be fixed according to DHEW regulations.

Community rating.—The Public Health Service Act requires Federally qualified HMO's to determine their payment rates for basic health services under a community rating system. Payments for supplemental health services must also be established under a community rating system if these rates are determined on a prepaid basis. Community rating requirements may be waived in certain circumstances.

Under a community rating system, the HMO must establish its rates based on the costs of providing health care to all its enrollees. The HMO is not permitted to develop distinct payment rates for individual groups based on cost experience of each group. Setting rates according to a group's cost experience takes into account certain variables which may include the group's claims experience, age, sex, and health status. Payment rates determined under a community rating system are intended to spread the costs of illness evenly over all enrollees in the HMO, rather than charging the sick more for health care than the well.

The law permits certain variations in HMO payment rates. For example, HMO's are permitted to establish different rates for individuals and for families. However, rates must be equivalent for all individuals and families of similar size.

S. 3327 and H.R. 11728 (92nd Congress), and all subsequent versions of these bills in the 93rd Congress, required HMO's to establish payment rates for each bill's basic benefit package under a community rating system. Differentials were allowed for family size. The bills did not require payments for optional services to be community rated. During the 1973 conference, a substitute amendment was adopted which required community rating for all basic health service payments and for those supplemental health service payments determined on a prepaid basis. The House legislation contained a provision, adopted in conference, which defined the term "community rating system."

House sponsors of H.R. 16782 (92nd Congress) and H.R. 51 and H.R. 7974 (93rd Congress) expressed concern that the new HMO's might be financially jeopardized if required to use a community rating system during their early years of operation. Therefore, these bills included a provision waiving the community rating requirement during an HMO's first year of operation if it could be demonstrated that use of the system forced the HMO to set noncompetitive rates for its health benefits package. Other health benefit programs generally establish premiums on an "experience basis" and can offer some groups lower rates based on tailored benefit packages and specific group characteristics. The waiver proposed by the House legislation was not adopted by the 1973 conferees.

Sponsors of the 1976 HMO amendments continued to express concerns about the impact of community rating requirements on HMO's. H.R. 9019, as reported, proposed to waive community rating requirements for five years after an HMO became Federally qualified for the employees health benefits plan in existing law, known as "dual choice." ("Dual choice" will be discussed in detail below.) S. 1926, as reported, however, modified this provision to waive community rating requirements for basic health service payments for three years. This waiver would be applied only to prepaid group health plans providing health services before qualification. New HMO's would not be eligible for the waiver. The Conference agreement on the 1976 Amendments generally conformed to the Senate's amendment. Conferees extended the length of the waiver to four years and modified it to apply to supplemental as well as basic health service payments.

Open enrollment.—The Public Health Service Act requires Federally qualified HMO's to maintain annual open enrollment periods during which the HMO must enroll new members as they apply, without regard to their health or disability status. The law modifies this requirement by: (1) applying the requirement only to large or mature HMO's; (2) limiting the number of new members seeking enrollment during this period; (3) permitting the HMO to reject institutionalized persons seeking membership; and (4) granting a waiver.

Early debate on HMO's in the 92nd Congress indicated House and Senate consensus on requirements for open enrollment. During later debate on this issue, there was little consensus. S. 3327 (as introduced) and H.R. 11728 contained similar open enrollment provisions. Under the Senate bill, HMO's were required to maintain annual open enrollment periods of at least 30 days, during which new members were to be enrolled in an unrestricted manner. The bill qualified this requirement by subjecting it to a general limitation on the number of persons to be enrolled from medically underserved areas (specifying a maximum of 50 percent of total membership, except in rural areas).

H.R. 11728 also required HMO's to have annual unrestricted open enrollment periods. Its provision was qualified in two ways: (1) The Secretary of HEW was permitted to authorize variations in the HMO's open enrollment policy; and (2) if compliance with PHS Act open enrollment requirements caused the HMO to be out-of-compliance with title 18 Social Security requirements (Medicare), then PHS Act requirements would not apply.

H.R. 16782 and all subsequent versions of this legislation in the House during the 92nd and 93rd Congresses did not require Federally

qualified HMO's to maintain open enrollment periods. The bills only specified that the HMO must enroll persons broadly representative of the various age, social, and income groups of the community served by the HMO. S. 3327 (as reported) and all subsequent versions of this legislation in the 92nd and 93rd Congresses retained the open enrollment provision with an added qualification. Open enrollment requirements could be waived for three year periods if maintenance of the policy caused: (1) disproportionate enrollment of high-risk members; (2) the HMO's total enrollment to be nonrepresentative to the community; and (3) financial jeopardy. An additional condition for waiver, based on a premium subsidization program contained in the Senate bill, specified that premium subsidy funds must be unavailable before the waiver could be granted.

The 1973 Conference agreement on HMO legislation conformed substantially to the Senate position on open enrollment. HMO's would be required to have annual unrestricted open enrollment periods. Three year waivers could be granted. However, the conferees amended the provision limiting the overall maximum membership of enrollees from medically underserved areas by increasing it to 75 percent of total membership (from 50 percent). The House requirement to insure that HMO total membership be broadly representative of the community was included.

H.R. 9019, as reported in the 94th Congress, proposed to eliminate entirely the open enrollment requirement in existing law. S. 1926, as reported, proposed a modified open enrollment policy to be applied only to large or mature HMO's. Under the Senate provision, an HMO which has existed for at least five years or has a membership of at least 50 thousand persons and has not incurred a deficit for its most recent fiscal year would be required to have an unrestricted annual open enrollment period. The Senate bill included certain qualifications, however. It specified that (1) the HMO need not continue to comply with the open enrollment requirement if it enrolled during the open enrollment period new membership equal to four percent of its total net increase in new enrollment during the preceding year (2) institutionalized persons seeking membership need not be accepted; and (3) benefits for members enrolled during the open enrollment period need not become effective for 90 days after enrollment. The bill also specified that for purposes of determining the four percent increase in new members the HMO was not permitted to include new members enrolled through groups which have existing contracts with the HMO. The Senate bill continued to permit a three-year waiver of open enrollment requirements; but, modified it to allow the waiver only if the HMO demonstrates that compliance would jeopardize economic viability. The 1976 Conference adopted the Senate provisions with certain modifications. Limits on increases in new membership during the open enrollment period would be based on a three percent (rather than four percent) net increase in new membership in the preceding year.

Services of health professionals.—The Public Health Service Act requires HMO's to provide basic health services to its enrollees through members of its own staff, through medical groups, through individual practice associations (IPA's), under contract with individual health professionals, or through any combinations of these sources. The law

limits the amount of contracting an HMO is permitted to undertake with individual health professionals and provides detailed requirements for medical groups and IPA's.

S. 3327 as introduced in the 92nd Congress (and subsequent versions of this legislation in the 92nd and 93rd Congresses) required HMO's to provide basic benefits through the HMO's staff or through medical groups. It contained a definition of the term "medical group" which required the group to be a partnership or association of health professionals composed of at least four licensed physicians or dentists. The group had to meet five additional requirements. Members of the group had to:

(1) Engage in the coordinated practice of their profession as a group responsibility and as their principal professional activity;

(2) Pool their income from their group practices and distribute it among themselves according to a prearranged salary plan or drawing account;

(3) Share records, equipment, and staff;

(4) Share additional health professionals needed to provide basic benefits; and

(5) Arrange for continuing medical education for group members.

S. 3327 (as reported and passed in the 92nd Congress) and S. 14 (as introduced and reported in the 93rd Congress) retained this definition of medical group with one difference. Physicians or dentists had to compose the majority of the group. These bills also contained an added provision that permitted certain organizations known as medical care foundations to qualify for Federal HMO assistance. It permitted, for purposes of Federal assistance, such organizations to provide prepaid health services to enrolled populations, even though the organizations did not meet many of the legislation's stringent requirements for HMO's regarding benefit packages, community rating, open enrollment, and medical groups. Termed "supplemental HMO's" by the legislation, these organizations were permitted to provide physician's services directly through their own members or through group of practitioners. Physician groups providing services for supplemental HMO's were reimbursed primarily on an aggregate fixed sum basis or on a per capita basis. The legislation permitted individual members within such groups to be reimbursed on a fee-for-service basis.

S. 14, as passed by the Senate, contained a substitute amendment which deleted provisions regarding supplemental HMO's. However, the legislation as passed, permited individual "medical group" members to be reimbursed on a fee-for-service basis, although the entire group had to be reimbursed on an aggregate fixed sum or per capita basis. In addition, medical group members were allowed to distribute their income according to other unspecified plans, as well as prearranged salary plans and drawing accounts.

H.R. 11728 as introduced in the 92nd Congress like the Senate bills, required HMO's to provide basic health services through the HMO's staff or through medical groups. The definition of "medical group" contained in the House bill was almost identical to that of S. 3327 (as introduced) with two exceptions. The group had to (1) be totally composed of licensed physicians or dentists, and (2) pool their income

from their group practice according to a prearranged plan or enter into an employment arrangement with an HMO to provide services. H.R. 11728 in addition, permitted the Secretary of HEW to vary the legislation's requirements for medical groups providing services for HMO's, during the HMO's first three years of operation.

H.R. 16782 (92nd Congress) and H.R. 51 and 7974 (93rd Congress) substantially altered certain provisions regarding the services of health professionals in H.R. 11728. HMO's would be required to provide basic health services through staff, medical groups, or individual practice associations (IPA's). H.R. 16782's definition of "medical group" was identical to that contained in H.R. 11728 with two important differences. First, the group could be composed of any licensed health professional. Second, members were not required to pool their income from their practice according to a prearranged plan or enter into employment arrangements with the HMO. The legislation also permitted HMO's to provide services through IPA's. IPA's, similar to the Senate's supplemental HMO, were added to the House bill to enable HMO's to provide health services through medical care foundations. An IPA was defined as a partnership, corporation, association or other legal entity that has an arrangement with licensed health professionals. Under the arrangement's terms, these professional must provide professional services according to a compensation arrangement established by the IPA. They must also, to the extent feasible, share records, equipment, staff, provide for continuing education, and use additional health personnel, as needed.

The 1973 conference agreement conformed generally to the House provisions. HMO's were required to provide basic health services (except those that are unusual or infrequently needed) through staff, medical groups, or IPA's. The House legislation's definition of an IPA was adopted with an added requirement that the majority of professionals under an arrangement with an IPA must be physicians. The Conferees adopted a substitute definition for medical groups, combining major requirements of the House and Senate provisions. The conference substitute defined a medical group as a partnership, association or other group (A) which is composed of health professionals licensed to practice medicine or osteopathy and of such other licensed health professionals (including dentists, podiatrists, and optometrists) as are necessary to provide the health services for which the group is responsible; (B) of which a majority of the members are licensed to practice medicine or osteopathy; and (C) whose members (i) as their principal professional activity and as a group responsibility engage in the coordinated practice of their profession for an HMO; (ii) pool their income from the practice and distribute it according to a prearranged salary or drawing account or other plan; (iii) share medical and other records and substantial portions or major equipment and staff; (iv) utilize additional personnel (as defined by the Secretary's regulations, as are available and appropriate for the effective and efficient delivery of the services of the members of the group; and (v) arrange for and encourage continuing education in the field of clinical medicine and related areas for the members of the group.

Sponsors of the 1976 Amendments to the HMO legislation proposed a number of changes to existing law requirements for the provision of

health services. H.R. 9019, as reported, permitted HMO's to contract directly with individual health professionals to provide basic health services even though these professionals did not qualify as medical groups or IPA's or provide unusual or infrequently needed services. S. 1926, as reported, did not contain this provision. The Conference agreement adopted a compromise provision. HMO's could contract directly for professional services with individual health professionals or groups of health professionals that do not meet the laws' requirements for medical groups. However, the provision limited the dollar amount of the contract to a maximum of 15 percent of the total amount paid by the HMO to its physicians (30 percent maximum for HMO's serving rural areas). H.R. 9019, as reported, added another provision, adopted by the 1976 Conferees, that would permit an HMO to provide basic health services through any combination of staff, medical groups, IPA's or professionals under contract.

H.R. 9019, as reported, waived for five years, the requirement that medical group members providing services for an HMO provide these services as their principal professional activity (generally interpreted to mean more than half of their time is devoted to the group). The waiver would apply after the HMO became Federally qualified for purposes of the dual choice program. S. 1926, as reported, did not waive this requirement. It did change the requirement to specify that medical groups must have a "substantial responsibility" for the delivery of health care to HMO enrollees. Senate report language interpreted "substantial responsibility" to mean that such groups must devote at least 35 percent of their time to the HMO rather than a minimum 51 percent. The 1976 Conferees adopted a substitute provision that would require individual members of the group to devote more than half their time practicing for the group, while the entire group must devote "substantial" amounts of time providing services to the HMO (interpreted to mean more than 35 percent). This requirement would be waived for up to three years for medical groups serving HMO's qualified to participate in the dual choice program.

S. 1926, as reported, contained several amendments not in the House legislation. All were adopted during the 1976 Conference. First, medical groups would be required to distribute their income according to plans which must be unrelated to the provision of specific health services. Second, the enrollment status of a patient receiving care (whether the patient is receiving care on a prepaid or fee-for-service basis) would not be divulged to the health professional at the time the service is provided. Third, existing and newly created IPA's could provide services without creating duplicative corporate structures.

Capitation grants.—S. 14 as passed by the Senate (93rd Congress), contained a provision which directed the Secretary of HEW to make annual grants to HMO's during their first three years of operation to provide health services to individuals who were unable to afford the enitre amount of the HMO's premium for basic services. Individuals assisted by this grant were expected to contribute some portion of the premium. The grant amount (with certain limitations) was determined by a formula equal to the number of people assisted multiplied by the premium amount with adjustments made for any contributions received. This provision was not adopted during the 1973 Conference.

(Note: S. 3327, as introduced and S. 3327 as reported in the 92nd Congress, and S. 14 as introduced in the 93rd Congress contained similar but different versions of this grant program.)

H.R. 16782 (92nd Congress) and H.R. 51 and H.R. 7974, as introduced, (93rd Congress), authorized a demonstration grant program to enable HMO's to offer membership to persons in their service area who were unable to pay all or part of the basic health service premium. Sixteen grants were authorized, eight to go to HMO's serving rural areas and eight to HMO's in urban areas. The grant amount, to be determined by the Secretary (with certain limitations), was to last for three years. H.R. 7974 as reported and passed did not contain this provision.

Premium subsidies.—S. 14 as passed by the Senate, (93rd Congress) contained a provision that directed the Secretary of HEW to make annual grants to HMO's (during their first three years of operation) that proposed to increase their premium rates because they enrolled a disproportionate number of high-risk enrollees. These grants could be made only if the premium increases were a direct result of the HMO's policy of unrestricted open enrollment. The amount of the grant (with certain limitations) would be equal to that portion of the HMO's proposed premium increase caused by the enrollment of such individuals. The provision was not adopted during the 1973 Conference. (Note: This provision, with certain modifications, was contained in all previous versions of S. 14 in the 92nd and 93rd Congresses, except S. 3327, as introduced.)

H.R. 16782 (92nd Congress) and H.R. 51 and H.R. 7974 as introduced, (93rd Congress) authorized a demonstration grant program to enable HMO's to offer membership to high-risk individuals who were unable to purchase health insurance at reasonable rates. A maximum of eight, three-year grants were authorized. The grant amount, as determined by the Secretary of HEW, was to cover the difference between the HMO's income from the basic health service payments of these high-risk individuals and the HMO's expenses for basic health services provided to such persons. H.R. 7973, as reported and passed did not contain this provision.

Assistance to HMO's in rural areas.—Prior to Senate passage of S. 14 in the 93rd Congress, all Senate versions of the bill contained a provision authorizing Federal grant and loan assistance to Health Service Organizations (HSO's). HSO's were rural HMO's that were not required to meet all of the legislation's requirements for HMO's. For example, HSO's were not required to provide the entire basic benefit package, but were permitted to phase-in certain services. During Senate passage of S. 14, a substitute amendment to the legislation was proposed and adopted that deleted provisions for HSO's. However, a floor amendment was passed to authorize separate appropriations for special grants and loans for all phases of HMO development and initial operation to "nonmetropolitan HMO's" or to entities intending to become HMO's in nonmetropolitan areas. The 1973 Conferees adopted a compromise provision that required 20 percent of the funds appropriated for HMO assistance to be used to assist HMO's in rural areas.

H.R. 16782 in the 92nd Congress (and H.R. 51 and H.R. 7974 as introduced in the 93rd Congress) authorized a demonstration grant

program to determine the feasibility of establishing HMO's in rural medically underserved areas. Twenty, three-year grants were authorized. The grant amount, as determined by the Secretary (under certain limitations), was to cover the additional costs to the HMO for establishing and operating transportation and communication systems. This provision was not contained in H.R. 7974, as reported and passed.

Construction assistance to HMO's.—Senate legislation in the 92nd and 93rd Congresses (S. 3327, S. 14) contained provisions authorizing grants, loans, and loan guarantees, and interest subsidies to enable HMO's (or entities intending to become HMO's) to construct ambulatory service facilities and to provide capital investment for transportation equipment used by the HMO to provide health services to enrollees. This provision was not adopted by the 1973 Conferees.

Various House HMO bills during the 92nd and 93rd Congresses also contained construction assistance provisions for HMO's. H.R. 11728 (92nd Congress) authorized HMO construction grants for ambulatory service facilities in medically underserved areas. It also authorized construction loans for ambulatory facilities without requiring the facility to be located in a medically underserved area. H.R. 16782 and H.R. 51 (93rd Congress) contained different construction assistance provisions. These bills authorized loans and loan guarantees to construct outpatient facilities and hospitals for HMO's. Provisions of H.R. 7974 (as introduced in the 93rd Congress) limited construction assistance to loan guarantees to construct HMO outpatient facilities and hospitals. H.R. 7974 as reported and passed in the 93rd Congress contained no construction assistance provisions.

Restrictive State laws.—Senate legislation in the 92nd and 93rd Congresses (S. 3327 and S. 14) contained provisions to supersede certain State laws that discouraged the development and operation of HMO's. Various House bills in the 92nd and 93rd Congresses contained similar provisions (H.R. 11728 and H.R. 16782, 92nd Congress, and H.R. 51 and H.R. 7974, as introduced, 93rd Congress). However, H.R. 7974 as reported, deleted these requirements from the House legislation. The 1973 Conference agreement adopted the Senate provision (with certain modifications).

H.R. 9019, as reported in the 94th Congress, added a new provision to existing law to require the Secretary of HEW within six months after enactment of the 1976 amendments to notify States with laws that impose restrictions on HMO operation if these laws are superseded by Federal law. S. 1926, as reported, required the Secretary to develop a digest of State laws and regulations regarding HMO's, which would be provided annually to each State. The 1976 Conferees adopted a compromise which generally conformed to the Senate provision requiring the digest to indicate State laws inconsistent with Federal law and incorporating the House bill's six month deadline.

Employee health benefits plan.—H.R. 16782 (92nd Congress) and all subsequent versions of this legislation in the 93rd Congress contained a provision, known as "dual choice" that required employers subject to minimum wage provisions of the Fair Labor Standards Act who employed at least 25 employees to offer their employees the option of joining a Federally qualified HMO. This option was to be a part of any health benefit program offered by the employer, as long as a

qualified HMO was providing services in areas where employees resided. Employers not complying with this requirement would be considered in violation of the Fair Labor Standards Act. Senate legislation did not contain this provision. The 1973 Conference adopted the House provision in substantially the same form.

H.R. 9019 and S. 1926, (94th Congress) amended existing law "dual choice" provisions in a similar manner to:

(1) require employers of more than 25 employees to offer the dual choice option only when at least 25 of their employees resided in a qualified HMO's service area. S. 1926 added a definition of "service area" which was dropped in conference;

(2) subject employers out-of-compliance with the dual choice provisions to a civil penalty (rather than to violations of the Fair Labor Standards Act);

(3) exempt the Federal government and certain religious organizations from dual choice requirements. The exemption for religious organizations was added by a Senate provision; and

(4) require the DHEW to integrate administration of the dual choice provisions with other HMO Act enforcement provisions.

These four provisions are now part of existing law.

Coordination with the Social Security Act.—S. 3327, as passed by the Senate (92nd Congress) and S. 14 (93rd Congress) contained a provision to ensure that the Public Health Service Act requirements for HMO's would not supersede Social Security Act requirements for HMO's set forth in title 18 (Medicare). This provision was added as a floor amendment during Senate passage of S. 3327. The 1973 Conferees adopted the intent of this provision, but redrafted it to ensure that no conflict would exist. The following provisions were specified: (1) basic health services for Medicare beneficiaries would be limited to Medicare's covered services under Parts A and B; (2) payments for such services would not be community rated; and (3) the HMO would not be required to be at risk for these services.

Senate HMO legislation in the 94th Congress (S. 1926, as reported) amended Medicare's definition of an HMO to make it more consistent with Public Health Service Act requirements for HMO's. The bill also added a new section to the Medicaid law (title 19 of the Social Security Act) which for the first time defined HMO's for purposes of receiving Federal matching funds and prohibited (with certain exceptions) payments to other organizations providing services on a prepaid risk basis. In general, the provisions contained in S. 1926 were adopted by the 1976 Conferees. Under the provisions, as agreed to in Conference, HMO's under Medicare and Medicaid are required, with certain exceptions, to provide services in the manner specified by the PHS Act. For Medicare, "basic services" are those provided under Parts A and B of the program, while for Medicaid the term refers to the mandatory list of services (except for SNF and EPSDT services). For Medicare, HMO's are exempted from employing a community rating system and payments and premiums must be in accordance with Title XVIII requirements. Both programs, with certain exceptions, are required to be organized and operated in the manner prescribed by the PHS Act. However, Medicare open enrollment provisions apply.

The PHS Act requires HMO's under Medicare to have half of its enrolled members under age 65 while for Medicaid half of the enrollees may not be covered under either Medicare or Medicaid. If organizations show that they are making substantial progress toward meeting the enrollment provisions, application of these requirements may be delayed for three years for both programs. Medicare further requires, with certain exceptions, that HMO's have an annual open enrollment period. Medicaid, on the other hand, is governed by the modified open enrollment requirements of the PHS Act.

The PHS Act requires the Secretary to administer determinations for both Programs as to whether an organization is an HMO, through the Assistant Secretary for Health's office in an integrated fashion with the administration of the enforcement provisions of the PHS Act. Administration of the remainder of the HMO provisions under Medicare must be done through the Health Care Financing Administration. Under Medicaid, States are permitted to make provisional determinations as to whether an organization is a qualified HMO if no determination has been made by the Secretary within 90 days of application.

The amendments to Medicaid prohibit matching to organizations providing services on a prepaid risk basis unless the organization is a qualified HMO or unless it is one of the organizations specified in law [community health centers, migrant health centers, nonprofit primary health centers in rural areas under the Appalachian Regional Development Act of 1976, or organizations which have had long-standing contractual arrangements to provide Medicaid services (not including inpatient hospital services) on a prepaid risk basis].

FEDERAL FINANCIAL ASSISTANCE FOR HEALTH MAINTENANCE ORGANIZATIONS

Currently, the Public Health Service Act authorizes Federal financial assistance to health maintenance organizations (HMO's) or entities intending to become HMO's for feasibility surveys, planning and initial development costs, and intial operating costs. The legislative history of the development of these programs indicate considerable controversy between Senate and House sponsors of Public Health Service Act HMO legislation. Earlier legislation shows original Congresional agreement on the types of financial programs needed to support the development of new or expanding HMO's. However, with the 93rd Congress, major issues revolved around the amount of financial assistance needed, the scope and duration of such assistance, and the financial stability of newly operating Federally-assisted HMO's.

S. 3327 and H.R. 11728, 92nd Congress

S. 3327 AND H.R. 11728, 92ND CONGRESS

Feasibility surveys.—S. 3327 and H.R. 11728 authorized similar programs of financial assistance to HMO's for feasibility planning. Both bills authorized grants to public or nonprofit private entities to plan or study the feasibility of developing or expanding HMOs. The total amount of grant assistance to be awarded was limited to $250,000

per project. Under the Senate bill, the grant was to remain available for expenditure for two years after date of award. The House bill limited grant availability to one year from the date of award but permitted a second grant award in exceptional circumstances. Both bills encourage grantees to plan for HMOs that would serve medically underserved populations. The Senate bill gave priority to feasibility grant applicants who gave assurances that thirty percent of their total enrollment would be from medically underserved areas. The House bill required the Secretary when awarding such grants to insure that, grantees in the aggregate, would be expected to enroll at least 40 percent of total anticipated members from medically underserved populations, irrespective of the number of such members to be enrolled by a single HMO.

The House bill also required the Secretary to give authority to these applicants which demonstrated that feasibility studies would be conducted in conjunction with individuals that had previous experience and expertise in the HMO field. This provision was the first major indication of concern regarding the future financial stability of newly operating HMOs, once Federal financial assistance expired. Throughout the later debate on HMOs, House sponsors supported a limited program of financial assistance to HMOs intended essentially to provide HMO start-up costs on a demonstration basis. House sponsors of HMO legislation consistently indicated their intention that the Federal program was not to provide a continuing Federal subsidy for broadscale HMO development.

Initial development costs.—S. 3327 and H.R. 11728 authorized almost identical assistance for HMO initial development costs. In general, initial development assistance was authorized to assist HMO development prior to the HMO's first day of operation. The assistance was to be used by HMO's to implement enrollment campaigns; design benefit packages; develop administrative, organizational, and financial arrangements; recruit and train personnel; and for architects' and engineers' fees. Initial development grants were authorized for public and nonprofit private entities to cover portions of the costs of an initial development project. Grant amounts were limited to $1 million per project. Each bill included priorities for initial development grantees that would serve medically undeserved populations (same as priorities for awarding feasibility grants under S. 3327 and H.R. 11728).

S. 3327 and H.R. 11728 also authorized loan guarantees and interest subsidies on loans made by non-Federal lenders to private HMOs to cover initial development costs. The loan amount to be guaranteed, under each bill, was limited to 90 percent of the costs of an initial development project. Interest subsidies were authorized to reduce the net effective interest rate on loans guaranteed by three percent per year.

Initial operating costs.—Both S. 3327 and H.R. 11728 authorized grants, loans, loan guarantees, and interest subsidies to assist HMOs in meeting operating costs incurred during the first three years of operation. Under the Senate bill, grants were authorized to public or nonprofit HMOs to meet operating deficits incurred during that three year period. Grants were to be made only after the HMO had ex-

hausted other financial markets for such assistance (including loans and loan guarantees). Grant amounts were to be limited to no more than 100 percent of the operating deficit for the first year, 67 percent of the first year's deficit for the second year, and 33 percent of the first year's deficit for the third year. Loans were also authorized to public or nonprofit private HMOs to meet operating deficits during the HMO's first three years of operation. For the purposes of the loan program, operating deficits were defined as: operating costs in excess of gross revenues. Loan amounts were limited to 60 percent of such costs for the first year, 40 percent of such first year costs for the second year, and 20 percent of such first year costs for the third year.

The House bill authorized grants to HMOs to meet initial operating costs incurred during their first three years resulting from the HMO's operation or expansion into a medically underserved area. Grant amounts were limited in the first year to $750,000 or 60 percent of such costs (whichever is less), in the second year to $500,000 or 40 percent of such costs (whichever is less), and in the third year $250,000 or 20 percent of such costs (whichever is less). The bill also authorized loans to HMOs to meet portions of initial operating costs during an HMO's first three years of operation. The loan program was not tied to providing services in medically underserved areas. The amount of initial operating loans awarded in each of the three years (when added to any initial operating grants received) was limited to $750,000 or 60 percent of such costs in the first year (whichever was less), $500,000 or 40 percent of such costs in the second year (whichever was less), and $250,000 or 20 percent of such costs in the third year (whichever was less).

Both bills authorized loan guarantee and interest subsidy programs for private HMOs to meet portions of their initial operating costs for up to three years. The amount of loans guaranteed was limited to 90 percent of the principal of loans made for initial operating costs.

H.R. 16782, 92D CONGRESS (H.R. 51, AS INTRODUCED, 93D CONGRESS)

H.R. 16782, 92nd Congress, was a clean, marked-up version of H.R. 11728. This bill, in large part, represented the House sponsors position on Federal support for HMO development during the remainder of the HMO debate in the 92nd and 93rd Congresses. The bill's format, with the exception of appropriations authorizations (to be discussed separately below), was retained in successive versions of the legislation. In addition, the House intent that the Federal program was to assist only a limited number of developing HMOs for a specified time period became explicit with this bill.

Feasibility surveys.—H.R. 16782 was the first HMO bill to separate the concept of HMO feasibility surveys from actual planning for HMO development. As such, the bill authorized grants and contracts to public and nonprofit private entities for feasibility surveys to determine the practicality of developing or expanding an HMO. In addition, contracts were authorized to private entities to carry out feasibility surveys for HMO development in medically underserved areas.

The dollar amount of a grant or contract was limited to a maximum of $50,000. The aggregate amounts of grants or contracts for a feasibility project could not exceed 90 percent of the costs (up to 100 percent for projects in medically underserved areas). One grant or contract was permitted per project (one additional grant or contract was permitted if needed to adequately complete the project). Projects were to be completed within 12 months from the date of a grant or contract award.

Planning assistance.—H.R. 16782 authorized four types of planning assistance for planning projects to establish new HMO's or projects that would significantly expand the membership or area served by existing HMOs. Grants and contracts were authorized for public and nonprofit private entities. Loans were authorized for public entities, only. Loan guarantees (without interest subsidies) were authorized for private entities. Contracts were also authorized for private entities to conduct planning projects to establish or expand HMOs that would serve residents of medically underserved areas. Priorities were to be given to applicants for planning assistance that would provide services to medically underserved areas. Only one type of planning award was permitted per project, to be completed within 12-months from the date of the award (an additional award was allowed with the same twelve months completion requirement, if necessary to adequately complete the project.) The amount of assistance per planning project was limited to a maximum of $125,000. The aggregate amount of all awards received for one project could not exceed 90 percent of project costs (up to 100 percent for projects in medically underserved areas).

Initial development assistance.—H.R. 16782 authorized the same four types of assistance for HMO initial development costs as was authorized for planning assistance. Although the purposes for which initial development assistance could be awarded was no longer specifically outlined in the legislation, initial development was defined to include significant expansion of membership of areas served by an HMO. Priorities were to be given to applicants for initial development assistance that would serve medically underserved areas. The amount of assistance allowed for one project was limited to the lesser of: (1) $1 million or $25 multiplied by the number of HMO members anticipated to be enrolled when the HMO becomes operational (whichever is greater), or (2) 90 percent of project costs (up to 100 percent for HMOs that serve medically underserved areas.) The bill permitted HMOs receiving planning assistance to also receive initial development assistance within the same time period. Assistance for initial development could be awarded to applicants that had not received previous assistance under the Federal program; however, such applicants were required to have conducted sufficient planning for the anticipated HMO and to have determined the feasibility of establishing, expanding or operating the HMO for which assistance was requested.

Initial operating assistance.—H.R. 16782 authorized three types of assistance to cover HMO initial operating costs. Loans were authorized to public or nonprofit private HMOs to assist in meeting operating

costs incurred during the first three years of operation. Loans were also authorized to public and nonprofit private HMOs for initial operating costs that could be attributed to a significant expansion in the membership of areas served by an HMO during the first three years after the expansion occurred. Loan guarantees were authorized for any private HMO for the same purposes for which loans could be made to public and nonprofit HMOs. The bill specified that the amount of the principal on loans made or guaranteed could not exceed $1 million. Aggregate amounts of loans made, guaranteed, or both could not exceed $2.5 million.

This section of the bill included specific directions on the number of HMOs that could receive initial operating assistance. The provision represented the House's intent to control the scope and duration of the Federal HMO program. Initial operating loans and loan guarantees could not be made to more than 150 HMOs between fiscal years 1974 and 1976. Up to 40 HMOs could receive such assistance in fiscal year 1974; an additional 50 were permitted to receive awards in fiscal year 1975; 60 additional HMOs could be awarded such assistance in fiscal year 1976. Since initial operating assistance was the final form of assistance that could be awarded to a developing HMO, under the Federal program, this requirement implicitly limited the Federal program's authorization of assistance to 150 HMOs by the end of fiscal year 1976. The House viewed the various Federal programs for HMO assistance as a continuum, beginning with feasibility assistance and terminating with support for initial operating costs. House sponsors felt that an HMO which had participated in this four-part program, once the assistance ended, should be ready to assume the financial risk for providing care to its membership, without additional financial subsidies. The entire program of financial assistance coupled with the mandated dual choice program, aimed at expanding an HMO's ability to compete with other health providers for enrolling members, was to be considered the total Federal program of support for a new or expanding HMO.

This intention was reaffirmed, in the Conference report on the 93rd Congress legislation:

> The Conferees noted that the purpose of this legislation is to stimulate greater provider and consumer interest in and awareness of the HMO concept of health care delivery. This is to be achieved through a combination of financial assistance and improved access to potential markets. The program is designed to assure that all assisted projects will be operational during the last year for which authority is given; the legislative program is for that reason considered to be self-contained and it is intended that its purposes be accomplished within the time and limitations of this authority. The House and Senate committees intend to exercise their oversight responsibility with respect to the programs authorized by the new title XIII.[52]

[52] Conference report on S. 14, the Health Maintenance Organization Act of 1973. House Report 93–714. 93rd Congress, 2nd Session.

S. 14 AND H.R. 7974, 93D CONGRESS

As passed by the Senate in the 93rd Congress, S. 14 retained almost all of the provisions for financial assistance included in the previous versions of the Senate bill (S. 3327). Although authorization levels changed significantly, few other substantive changes were made.

H.R. 7974 as reported and passed during the 93rd Congress was essentially similar to H.R. 16782 in the previous Congress. Like S. 14, authorization levels were altered, but few other changes were made. HMO planning projects were defined to include the development of marketing plans and feasibility planning. Applicants for loan guarantees for HMO initial operation would be required to serve residents of medically underserved areas. The overall limit on the number of HMOs that could receive initial operating assistance was removed from the House bill, as reported, but the House report clearly stated Congressional intent with respect to the numbers of HMOs to be assisted:

> Much discussion has occurred during the committee consideration of this legislation of the number of HMO's which should be developed under the program sponsored by the bill. Earlier versions would have limited the Department of Health, Education, and Welfare to the development of either 150 or 100 new HMO's. The legislation reported contained no absolute limit although it is anticipated that the limit of authorizations process will provide an effective ceiling on the number of HMO's which could be established. Clearly, the number of HMO's which can be established will depend on several things including the actual costs experienced in establishing new HMO's, the number of HMO's which HEW has already assisted which qualify for assistance under this legislation, and the successes and problems of HMO's established in the first years of this program. Generally, however, the Committee would anticipate that this legislation would be used to bring the operating state approximately 100 new HMO's.[53]

House and Senate authorizations for Federal HMO assistance.— The Senate legislation, throughout the entire debate on HMO assistance, authorized separate appropriations for each program of HMO assistance contained in the legislation. Earlier versions of House HMO legislation also authorized separate appropriations for individual programs. However, H.R. 7974, as reported and passed, contained an aggregate authorization for grants and contracts for feasibility, planning, initial development and initial operating assistance. A separate aggregate authorization was made for initial development and operating loans in the last year for which such funds were authorized. This bill also authorized funds in the aggregate to be appropriated to a revolving loan fund from which loans were to be made.

[53] H. Report 93–451. Report of the Committee on Interstate and Foreign Commerce on H.R. 7494, 93rd Congress, 1st Session.

Feasibility and planning assistance.—The program of feasibility and planning assistance, as agreed to in conference, generally conformed to the House legislation although certain provisions of the Senate bill were retained by the conferees. Grants and contracts were authorized to public or nonprofit private entities for surveys or other activities to determine the feasibility of developing and operating or expanding the operation of an HMO. Grants and contracts were authorized separately for public or nonprofit private entities for planning projects to establish HMOs or to significantly expand the membership of or areas served by HMOs. Loan guarantees for private profitmaking entities were authorized for planning projects to establish or expand HMOs that would serve medically underserved populations. Feasibility grants and contracts were limited to $50,000 per grant or contract; single grants or contracts for planning were limited to $125,000.

The Senate provision requiring that priority be given to applicants for feasibility and planning assistance that will enroll at least 30 percent of their total enrollment from medically underserved areas was retained.

Initial development.—The conferees agreed to a substitute provision for HMO initial development assistance. Grants and contracts for public or nonprofit private entities were authorized for projects to initially develop HMOs. Loan guarantees for private profitmaking entities were authorized for projects to initially develop HMOs that serve medically underserved populations. The Senate provision outlining the purposes for which initial development assistance could be used was included, as was the House's definition of "initial development". The conferees combined provisions limiting the amount of initial development assistance that could be provided to equal the lesser of $1 million or 90 percent of project costs (up to 100 percent for HMOs serving medically underserved populations). The conferees included the House provision requiring that sufficient planning must be completed and feasibility of a project demonstrated before initial development assistance could be awarded. Senate provision for priority for HMOs serving medically underserved populations was retained.

Initial operating assistance.—The Conferees dropped the Senate provision authorizing initial operating grants. The Senate provision authorizing loans for initial operating deficits was retained. The House provision guaranteeing initial operating loans for private HMOs that served residents of medically underserved areas was retained, but the provision included the Senate bill's requirement that limited such loans to the costs incurred during the first three years of an HMO's operation. House provisions limiting the amount of assistance for HMO initial operating loans and loan guarantees were retained.

Authorization levels.—Prior to Senate passage of S. 14, the Senate bill authorized $427.5 million of HMO feasibility, planning, initial development, and initial operating assistance. This included authorizations for health service organizations (see previous discussion of health service organizations). However, during Senate passage of

S. 14, a compromise amendment was adopted that reduced authorization levels for such assistance to a total of $285 million for three fiscal years (fiscal year 1974 through fiscal year 1976). This amendment also deleted authorizations of assistance to health service organizations. The Senate-passed bill continued to provide separate authorizations for each program.

The House-passed bill provided no separate authorizations for feasibility, planning, and initial development programs for fiscal year 1974 through 1976. A total of $135 million was authorized to be appropriated for grants and contracts for these programs for fiscal year 1974 through 1976. The Senate bill proposed increases in existing law limits for such projects.

In general, the Conferees agreed to the Senate's proposals. The limit on the amount of Federal assistance for a feasibility grant or contract was increased to $75,000 per grant or contract in a single year (from $50,000). The limit on the amount of Federal assistance for planning projects was increased to $200,000 per project (from $125,000). Limits on initial development projects were increased to $1.6 million for projects assisting qualified HMOs to provide services in additional service areas or in one or more service areas which are not contiguous. The existing annual limits on initial operating loans ($1 million) were retained, as was the existing $2.5 million total limit on loan assistance, but the period for which loans could be made available was extended from three to five years.

HMO COMPLIANCE AND EVALUATION

A variety of provisions in House and Senate HMO legislation during the 92nd and 93rd Congresses contained requirements for HMO program compliance and evaluation. S. 3327, (92nd Congress) and S. 14, (93rd Congress) contained, in general, almost identical requirements for HMO compliance with program conditions. Requirements for evaluation were not as clearly specified in the Senate bill, as in the House legislation. However, the Senate legislation did authorize a Commission on Quality Health Care Assurance to set standards for HMOs and monitor HMO performance (among other functions). In general, the Senate legislation (during the 92nd and 93rd Congresses) contained the following requirements:

(1) HMOs had to make, during the period financial assistance was received and after assistance had ended, full and complete reports that provided special assurances to the Secretary on (a) populations groups served, (b) enrollment, (c) method, terms, and periods for enrollment, (d) costs per enrollee for health and educational services, (e) sources of professional services, and organizational arrangements, (f) arrangements for ongoing quality assurance programs, (g) prepayment sources and other sources of payment for services, (h) facilities available and sources of additional capital financing, (i) administrative, managerial, and financial arrangements, (j) enrollee participation in planning and policymaking, (k) grievance procedures, and (l) support for the HMO by populations served, sources of operating support, and professional group involvement.

(2) HMOs were required to submit continuing reports to the Secretary that satisfactorily demonstrated (a) financial responsibility and (b) development and operation consistent with the provisions of the legislation and the assistance applications.

(3) HMOs were required to satisfactorily demonstrate the maximum number of people that could be served effectively.

(4) HMOs in noncompliance with set standards would become ineligible to participate in the Federal program. Those HMOs in noncompliance for unreasonable periods of time would become liable for repayment of Federal financial assistance.

(5) HMOs making false statements on applications for assistance could be fined up to $10,0000, imprisoned for six months, or both.

(6) HMOs had to provide the Secretary of HEW and the General Accounting Office (GAO) with full and complete access to financial and other records on projects assisted with Federal funding.

House requirements for HMO compliance and evaluation were set forth in H.R. 7974, as reported in the 93rd Congress. Earlier versions of the legislation differed in certain respects from the requirements in H.R. 7974, as reported. However, the provisions contained in the reported bill represented the House's basic intent that the operations of newly operating HMOs were to be closely monitored for program compliance and also to weigh the effects of such compliance on the HMOs ability to expand enrollments and maintain financial stability.

H.R. 7974, as reported:

(1) required the GAO to evaluate the operations of at least 50 Federally-assisted HMOs during their first three years of operation. An evaluation report to be submitted to Congress, was to contain GAO's finding on the HMO's ability to: (a) operate on a fiscally sound basis, (b) meet application assurances for HMO organization and operation, (c) provide basis and supplemental health services in the required manner, (d) include indigent and high-risk members in enrollments, and (e) provide services to medically underserved areas.

(2) required the Comptroller General to study the economic effects of compliance with the mandated dual choice provisions of the legislation on affected employers.

(3) authorized the Secretary of Health, Education, and Welfare to bring a civil action against any HMO assisted under the Public Health Service Act Federal program if the HMO (a) failed to provide basic and supplemental health services to its membership, (b) failed to provide such services as prescribed by the legislation, and (c) was not organized or operated as prescribed. The HMO compliance program was required to be administered by an identifiable unit within the Department of Health, Education, and Welfare.

The 93d Congress conference agreement on HMO compliance and evaluation provisions combined provisions of both the House and Senate bills. In general, Senate provisions regarding special assurances, requirements for continuing reports demonstrating financial responsibility and compliance with development and operational requirements,

and access to records were retained. House provisions permitting the Secretary to bring civil actions against HMOs out-of-compliance with Federal program requirements were also retained, as were provisions requiring GAO evaluations.

1976 amendments.—House and Senate HMO legislation did not significantly alter existing law programs for evaluation and compliance. Both bills, as reported, added a provision that allowed the Secretary of Health, Education, and Welfare (1) to notify HMOs that were out-of-compliance with program requirements, (2) suspend such HMOs Federal qualification for purposes of mandated dual choice until compliance was achieved, and (3) notify affected employers and collective bargaining agents of such suspension.

In addition, both bills decreased the existing law requirement on the number of HMOs to be evaluated by GAO to at least 10 or one-half of those being assisted (whichever is greater) who are qualified for the purpose of the dual choice program by the end of calendar year 1976. This provision was included because too few federally-qualified HMOs were in operation to enable GAO to meet the requirements of the law.

V. Progress in Implementing Public Law 93–222

Public Law 93–222, the HMO Act of 1973, enacted on December 29, 1973, authorized grants, loans and loan guarantees and the mandatory dual choice option requiring employers to offer HMO's to their employees. Funding under this Act began on July 1, 1974. In Fiscal Year 1975, 108 feasibility, 31 planning, and 33 initial development grants were awarded to 157 projects in 42 states. Fifty-nine million dollars in requests were submited and $22.5 million was actually awarded. Due to decreased appropriations, funding in Fiscal Year 1976 concentrated on continuing existing grantees. Seventy-two grant awards were made to 64 grantees, comprising a total expenditure of $18.1 million.

Restrictive elements of the HMO Act and delays in the issuance of the "dual choice" regulations contributed to delays in the expected HMO growth. In an attempt to rectify this situation, P.L. 94–460, the Health Maintenance Organization Amendments of 1976, was signed into law in October 1976. At that time, there were a total of 21 qualified HMO's with 61 pending applications and over 150 organizations expressing intention to seek qualification in the future. These amendments were designed to improve the ability of qualified HMO's to compete in the market place.

On September 30, 1977, 43 HMO's were qualified under the Act. Seventeen loans totaling $33,179,000 and two loan guarantees totaling $2,282,000 were committed during Fiscal Year 1977. That same fiscal year saw a decrease in grant activity with $16.9 million being spent on 46 grants to 42 grantees: including 5 feasibility, 15 planning, and 26 initial development grants.

In the latter part of 1977, Department of Health, Education and Welfare Secretary Califano and Under Secretary Champion initiated a reorganization of the Federal HMO program and began aggressive measures to improve the program's productivity. As part of this new effort by the Department has reorganized the HMO program, pub-

lished several sets of regulations, implemented a promotional effort, reduced the qualification backlog, and published a draft compliance plan to monitor qualified HMO's.

The Department has begun to encourage the development of high quality HMO's in a more aggressive fashion. The Department is now conducting a national market survey which should help to identify in a more rational way the best areas for HMO development. HEW is now also enlisting the support and involvement of the business and labor communities.

Yet the HMO program still faces several unsolved problems. According to the GAO, these include fragmented responsibility and uncoordinated efforts in operating the program, insufficient staff with expertise needed to administer the program effectively, and slow issuance of final regulations and guidelines for implementing and enforcing requirements of the Act. HEW has acknowledged these problems and has committed itself to resolve them.

Grant activity is expected to increase in Fiscal Year 1978 and is estimated by the Department of Health, Education and Welfare to include 60 feasibility grants; 9 planning grants; 20 initial development grants and 15 expansion grants. The number of grantees receiving support in Fiscal Year 1978 and the number which will be provided support by this bill should dramatically increase the number of qualified HMO's which as of July 1, 1978 was 63.

VI. Committee Report

EXTENSION OF PROGRAM (SECTION 2)

The reported bill extends the authorizations of appropriations for making grants and entering into contracts for undertaking feasibility surveys, planning, and the initial development of health maintenance organizations (HMO's). Section 10 of the bill establishes a specific authority for grants and contracts for training and technical assistance. Authorizations of appropriations for all grants and contracts (including those authorized under section 10) are $63,000,000 for each of the fiscal years 1980 and 1981. The bill also extends the authority to make loans and loan guarantees to support the initial costs of operation of HMO's through fiscal year 1981. (H.R. 12460, the "Health Centers Amendments of 1978," reported by the Committee on May 15, 1978, extends the authorizations of appropriations for grants and contracts for feasibility surveys, planning, and the initial development of health maintenance organizations for fiscal year 1979 at a level of $45,000,000.)

By extending the authorizations for the HMO program the proposed legislation changes the Federal role with respect to the program from one which was initally conceived as initial support of a demonstration program to one which provides support for HMO development on a continuing basis. HMO's are now viewed as a positive reform of the health care delivery system which provide an alternative to the more traditional fee-for-service practice of medicine.

One of the major advantages of HMO's is their cost containment potential. Their track record on this score has been encouraging as recent studies indicate that they can achieve overall cost savings from

10% to 40%. Much of this savings accrues by eliminating the overuse of inpatient hospital services. Recent statistics show that HMO members on average use only 488 days per thousand compared to the national average of over 1,000 days under the fee-for-service system. As the cost of hospitalization continues to rise at unprecedented rates, this reduction in hospitalization has even greater potential savings for the consumer.

Another advantage of HMOs is their ability to deliver health care of high quality in innovative modes. HMOs, particularly the group practice model, have the advantage of extensive peer review, and many have developed impressive quality assurance monitoring mechanisms. HMO's have the ability to assure greater continuity of care between physicians by sharing records and establishing mechanisms that enhance communication between providers of care. In addition, many HMOs have been experimenting with the use of allied health personnel, with innovative health screening programs and with new methods of organizing the delivery of services.

HMO's are difficult and complex organizations to establish. Federal support is provided to encourage entities to examine the feasibility of establishing an HMO, to undertake planning for an HMO once its feasibility has been determined, and to prepare for the HMO's establishment prior to its operation. Loan or loan guarantee support is provided to subsidize the initial costs of operation of an HMO. This support is particularly important to assist an HMO in the period of development and growth prior to the point where it enrolls a membership adequate to become financially self sustaining. The volume of membership needed to break even varies from HMO to HMO but can be as high as 30,000 members in staff model group practices. HMO development is not without risk. As with any business enterprise some may fail. Federal support is thus designed to assist potentially viable HMOs through these most difficult developmental stages.

The Federal HMO program is intended to achieve fair goals. First, the program should encourage the continued development of HMOs so that more consumers will have a choice between an organized system for providing care and the fee-for-service system. Second, the program should assure that all HMO's which are qualified by the Federal government are providing the required services in a manner prescribed by law. Third, it should thoroughly evaluate the potential of all applicants to become self sufficient HMOs and use Federal dollars to support only those with the greatest potential. Fourth, the program should encourage both competition between HMOs and traditional fee-for-service systems and financing mechanisms which support them and among multiple HMO's so that the consumer will have a choice among different systems of care.

While progress in achieving these goals has been slow, this bill is designed to provide impetus to expand HMO activity over the next three years. The Committee is encouraged by the Department of HEW's actions to strengthen the HMO program. The Administration has recognized administrative problems in the management of this program and has moved to improve its qualification and compliance activities. Steps have already been taken to reduce the large backlog of applications for qualification and to promulgate long overdue regu-

lations governing the program's operation. Plans are being developed for improved monitoring of grant and loan recipients, as well as for providing for more careful analysis of loan and grant and applications prior to their award. At the same time, the Administration has undertaken activities to promote the development of HMOs and is encouraging the business and labor communities to become more involved.

While the Committee is pleased that the Department is now moving ahead aggressively with the HMO program, it intends to monitor closely the Administration's activities to assure that progress is continued. The General Accounting Office has been specifically requested to review the Department's plans with regard to loan monitoring and the development of a formal loan policy. The Committee expects a report on these activities from the General Accounting Office by November 15.

REQUIREMENTS FOR THE PROVISION OF SERVICES (SECTION 3)

One purpose of title XIII is to encourage the development of HMOs which will compete with service and indemnity health insurance plans on the basis of price. In order to promote these competitive aspects, the Committee has included provisions in this legislation to permit certain limited exclusions from the required HMO benefit package for those services which are customarily not covered in the health benefit packages of service and indemnity health insurance plans. These limitations include financial responsibility for services covered by workmen's compensation or other third party medical insurance programs; the inability to provide services because of major natural disasters, war, civil insurrection or riots or other events not reasonably within the control of an HMO; services for which a member intentionally left the area; and those health services determined by the Secretary (upon request of the HMO) to be unusual, infrequent and unnecessary to protect the health of the member.

WORKMEN'S COMPENSATION AND OTHER LIABILITY

Under existing law, an HMO is required to provide its members all basic health services in exchange for a periodic fixed payment. No provision is made to allow an HMO to receive payments from other sources. The reported bill, while continuing to require that all basic health services be provided, would allow an HMO to seek reimbursement for services provided to a member who is entitled to benefits under a workmen's compensation law or an insurance policy. This amendment seeks to assure that financial responsibility for work-related illness or injury will be born by workmen's compensation programs and financial responsibility for other illnesses or injuries covered by an insurance policy will be borne by those policies. Without such a provision HMO members are required to bear the costs of work-related and other covered illness or injury in the monthly premium dues, while traditional health insurance purchasers are not. The result leads to an increase in the rates of HMO's.

Under the amendment, the HMO would provide the health care services and receive payment from the workmen's compensation car-

rier, employer or other third party responsible for payment. To the extent permitted under State law or relevant policy. To the extent that third party benefits for injury or illness are paid to an individual, the HMO may collect from the individual.

It is the Committee's expectation that an HMO, in calculating a community rate on a prospective basis, will estimate the amounts which are likely to be collected from workmen's compensation programs and other insurance which covers members and adjust the HMO payment downward to reflect these expected collections. Allowing a qualified HMO to exclude the cost of care covered by workmen's compensation or other third party payors places HMO's on a more competitive basis with other health insurers which are permitted to subrogate third party liability claims and coordinate benefits through the insurance policy.

PHYSICIAN CONTRACTS

Existing law limits the amount which an HMO may pay under contracts to health professionals or entities other than staff, medical groups or individual practice associations to 15 percent of the amount paid to physicians. The reported bill would remove the limit on contracting with health professionals other than physicians. Health professionals other than physicians are generally salaried employees of the HMO. The bill would allow an HMO up to five years to reduce its reliance on contracts with physicians other than staff physicians and those who are in medical groups or individual practice associations. At any time, the amount paid to such physicians could not exceed 50 percent of the total amount paid for the services of physicians, and in the fifth and succeeding years, the amount could not exceed 15 percent in urban areas or 30 percent in rural areas.

This existing provision of the law has created problems, particularly for staff model HMO's, and conflicts with the law's fiscal soundness requirements. An HMO is required to provide a full range of services on its first day of operation. To be financially viable, it cannot add to its staff all of the medical specialties that are needed to provide the full range of services to HMO members. Therefore, it is prudent for the HMO to enter into contracts with specialists to assure that all services are available until enrollment grows to a point where specialists can be added to the staff. The existing 15 percent requirement has prevented some HMO's from doing this and thus carrying out fiscally sound policies. This amendment will correct that situation.

INTENTIONALLY LEAVING THE AREA

The reported bill also amends existing law to remove the financial responsibility of an HMO for services provided by another organization to a member of the HMO if the member intentionally leaves the area served by the HMO for the purpose of securing those services. Existing law requires an HMO to provide basic health services without regard to dates, frequency, extent, or kind. A member is to be reimbursed for expenses in securing services that are medically necessary should services be required before the member could secure them from the HMO. It is not the Committee's intent to alter this provision of the

law except in the case where the member intentionally leaves the area to secure such services. The most likely case where this problem arises is where an expectant mother finds it is convenient to leave the HMO area to stay with family or friends and have delivery in another area. In this situation, the HMO has already arranged for medical resources to provide the member service and should not be financially responsible for care provided out of the area.

DISASTER, WAR, RIOTS, OTHER CIRCUMSTANCES

The reported bill requires an HMO to make a good faith effort to provide or arrange for the provision of services within the limitation of its facilities, personnel, or resources in the event of a major disaster, riot, civil insurrection or any other event not reasonably within its control. The Committee expects the Secretary to define the events subject to this provision in regulations. If a good faith effort has been made, however, and conditions make it impossible for an HMO to provide services or arrange for the provision of services by others, then it is relieved of the responsibilities to provide basic health services to its members. The Committee, in adopting this amendment, wants to make it clear than HMO is to provided or arrange for services if it is reasonably within its capabilities and financial resources to do so. If following a disaster or other event which make it impossible for an HMO to provide services, the HMO is once again able to provide services, then the Committee would expect it to do so.

UNUSUAL AND UNNECESSARY SERVICES

The reported bill allows an HMO to exclude from the basic health services which it provides to members any service which, upon its application, the Secretary determines is unusual and infrequently provided and not necessary for the protection of the health of the member. This section allows an HMO to seek approval for excluding a service which it feels should not be considered a basic health service. Such services might include purely cosmetic surgery, sex change operations or reversals of voluntarily induced infertility. The Secretary is required to publish in the *Federal Register* each determination made under this provision.

ORGANIZATIONAL REQUIREMENTS (SECTION 4)

Students and community rating

The reported bill would allow an HMO to provide services to full time students of an accredited institution of higher education for a payment that is not fixed under a community rating system. Existing law requires payments for basic health services from HMO members to be fixed under a community rating system. This provision of existing law has precluded an HMO from enrolling students because students as a group are generally healthy, require few services, and thus are unwilling to pay a high rate based on general community experience. Insurance companies or service benefit plans can offer coverage to students at rates which recognize their experience in using health

services which is significantly lower than other individuals or groups in the population. Students are thus likely to choose insurance or service benefit plan coverage for a premium which may, for example, be half as much as the community rated premium of the HMO.

The Committee continues to support the community rating concept because it assures that the risk of illness and its associated cost are shared by the population and its various subgroups. However, the Committee believes that it is important for students to have the HMO option since students are often away from their usual sources of medical care and might find an organized system of care to be attractive and convenient. The Committee also believes that students should have the opportunity to join an HMO so that they will be more likely to consider the HMO option in the future.

This amendment will allow universities and others to include students in their HMOs. The Committee wishes to make it clear, however, that HMOs serving only students would not meet the definition of an HMO under title XIII, since that definition requires the HMO to enroll members who are broadly representative of the various age, social and income groups within the area it serves.

ADMINISTRATIVE AND MANAGEMENT CAPABILITY

The reported bill also requires that an HMO have administrative and managerial arrangements and capabilities satisfactory to the Secretary. The Committee believes that qualified management is critical to an HMOs success. While existing law requires that applicants for Federal assistance provide assurances satisfactory to the Secretary that they have or will have "administrative, managerial and financial arrangements and capabilities which are satisfactory," existing law includes no comparable requirement for qualified HMOs. This amendment will allow the Secretary to assure that all qualified HMOs have at the time of qualification and continue to have the administrative and managerial capabilities needed to operate successfully.

ENROLLMENT OF MEMBERS

The reported bill allows the Secretary to promulgate regulations to restrict certain types of enrollment practices for members entitled to Medicaid benefits. The Committee looks with concern at evidence of marketing abuses which took place among the California prepaid health plans. Of particular concern were instances where enrollment was carried out in the home without the enrollee being fully aware of the purpose of the enrollment. This amendment is intended to allow the Secretary to prohibit fraudulent or abusive practices which might develop in the enrollment of Medicaid beneficiaries.

The Committee expresses its appreciation to the Permanent Committee on Investigations of the Senate Committee on Governmental Affairs for its recent report (Senate Report No. 95–749) on prepaid health plans and HMO's which highlighted improper practices which occurred in prepaid health plans in California. While these plans were not qualified HMOs. the report identified numerous potential problem areas for qualified HMOs. The Committee has used the report in developing this amendment as well as others in the bill.

PUBLIC HMO'S

The bill would also exempt public HMO's from the existing requirement that all HMO's have a policymaking body made up of at least one third of HMO members and include representation from underserved populations. The amendment would establish in its place a requirement that the public HMO have an advisory board which meets the same requirements as those for the policymaking body and to which may be delegated policymaking authority for the organization. The Committee believes that this amendment is necessary because in most cases the policymaking body for a public HMO is an elected unit of local government which may be precluded from changing its composition to meet the requirements of the Act. However, it is the Committee's intent that a public HMO give the advisory board a significant role so that the members of the HMO have a substantial voice in the operation and management of and the establishment policy for the HMO.

The Committee wishes to emphasize that a public HMO is required to meet all other requirements of title XIII including the requirement of 1301(c)(3) that the HMO enroll persons who are broadly representative of the various age, social and income groups within the area it serves. The Committee expects that a public HMO will provide the quality of care and high level of services necessary to attract a broad-based population. A waiver for a public HMO of the requirement of the Social Security Act that no more than fifty percent of the enrolled population be Medicare or Medicaid recipients could promote a two-class medical care system. The experience with the pre-paid health plans in California is sufficient evidence that an HMO, public or private, should not market exclusively to Medicare/Medicaid populations.

MEMBERSHIP

Section 1302(3) defines a member as "an individual who has entered into a contractual agreement, or on whose behalf the contractual arrangement has been entered into, with the organization under which the organization assumes the responsibility for the provision to such individual of basic health services and of such supplemental health services as may be contracted for." The Committee has received inquiries as to whether this definition includes an individual who is a policy holder in a health plan of a commercial insurance company or a member of a Blue Cross or Blue Shield plan which contracts with an HMO for the individual to be a member of the HMO. The Committee intends that such an arrangement be permitted, but only if the obligations of the HMO to the member under such an arrangement are no different from the obligations which the HMO would have if the individual contracted directly with the HMO.

FEASIBILITY SURVEYS AND INITIAL DEVELOPMENT (SECTION 5)

Feasibility surveys

Existing law allows Federal support of entities or HMOs which can not complete its feasibility surveys without Federal support. Because of this restriction Federal support is not available to many entities

which have the financial capability to develop and operate an HMO but which do not feel they can use existing funds to explore the feasibility of HMO development because of the risk associated with that phase of development. The reported bill would allow HEW to provide financial support for surveys to determine the feasibility of developing and operating or expanding the operations of an HMO to public or nonprofit private entities which have the financial capability to conduct such a survey. It is the Committee's intent that any public or private entity contribute its own resources in all phases of HMO development where that is possible. However, in cases where an entity has the potential of providing support for other phases of HMO development, HEW can make feasibility awards under this amendment without regard to an entity's financial position.

The Committee wishes to note that HEW's interpretation of this existing provision of law (section 1306(b)(2)), which requires the Secretary to determine that the entity making the application would not be able to complete the project or undertaking for which the application is submitted without the assistance applied for, is overly restrictive. The position taken by HEW is that the applicant must have no uncommitted assets in order to be eligible for Federal assistance. This has led to a situation where entities set up separate corporations with no assets to meet the requirements of this law, thus circumventing the purpose of the provision. The Committee feels that a more realistic interpretation of this provision would be one where HEW evaluates an entity's financial situation and determines whether or not the entity would be able to complete the project without the assistance requested even though it might have unobligated assets such as working capital.

Initial development

The reported bill also modifies the support available to organizations for initial development. Existing law requires that support for initial development not exceed $1 million, or in the case of a project for an HMO which will provide services to an additional service area or which will provide services in one or more service areas which are not contiguous, $1.6 million. Under the reported bill, an entity would continue to be eligible to receive up to $1 million to support its establishment as an HMO and would be eligible to receive up to $600,000 to support *each* significant expansion of membership or area served. Support under this provision would be available for up to three years.

The amendment clarifies the distinction in existing law between the establishment and significant expansion of an HMO. Significant expansion has been defined by the Secretary in regulations to mean (1) a planned increase in membership to be effected at a rate which exceeds the average growth rate of the HMO and which will require an increase in the number of health professionals serving members of the HMO or an expansion in the physical capacity of the total health facilities or (2) a planned expansion of the service area beyond the current service area which would be made possible by the addition of health services, delivery facilities and health professionals to serve members at a new site or sites in the areas previously without such service sites.

The Committee believes that any experience HMO which desires to expand its membership or service area should be eligible for support. This should maximize the potential for HMO development by allowing existing organizations that have the experience and expertise relating to HMO development and organization to expand to areas where there is likelihood of successful HMO development. The Committee notes, however, that the provisions of section 1306, requiring that Federal support be provided only in cases where the project undertaken could not be completed without such support, would apply.

Costs of operation (section 6)

The reported bill makes two changes in existing law with respect to the loans and loan guarantees which may be provided to an HMO once it has commenced provision of services to its members. Existing law permits the use of loans and loan guarantees for initial operating costs and sets an aggregate limit of $2.5 million and a limit of $1 million in any fiscal year. The reported bill expands the use of this support to any costs of operation, both operating costs and capital costs which an HMO incurs during its initial operation. The Committee expects that this would cover small capital costs, such as equipment or facility renovation, but that major capital costs such as construction and acquisition of facilities would be included in the new loans authorized by section 9 of the Committee's bill. The bill increases the total amount of loan and loan guarantee support for the cost of operation for which an HMO is eligible from $2.5 million to $4.0 million. This change reflects the effect of inflation since 1973 and provides that an HMO will have relatively the same amount of support available to it.

As the Committee considered this provision, concern was raised about HEW's ability to manage and monitor the loan program. The Committee is reasonably satisfied with the Department's plans to increase its capability in this regard. Those plans include the use of 37 new positions to augment the qualifications and compliance activities of the HMO program. Those activities support the administration of the loan program by determining the financial viability of the HMO and by monitoring HMO activities. In addition, the Department plans to increase the size of the staff working in the loan branch. This unit, in addition to working with the qualifications and compliance units, is involved in sizing loans, negotiating loan agreements, and coordinating advice and technical assistance. The Department also plans to develop a formal loan policy which, while part of a general Public Health Service loan policy, should make decisions under the loan program more systematic. The Committee's Subcommittee on Health and the Environment has specifically requested the General Accounting Office to monitor the Department's activities in carrying out these plans and in complying with the recommendations which the General Accounting Office made in its recent report to the Congress and report back to the Subcommittee by November 15.

Payroll deductions for health benefits (section 7)

The purpose of section 1310, Employee's Health Benefits Plans, is twofold. First, it gives qualified HMO's additional access to the marketplace by requiring certain employers to offer their employees the

option of membership in qualified HMOs. And second, it provides the employees of those covered employers with alternatives from which to choose their source of health services. Testimony received by the Committee indicated that the dual purposes of section 1310 are being fulfilled. The Committee is concerned, however, that existing law is not clear as to whether an employer who is required to offer his employees the option of membership in qualified HMOs is required to allow his employees to pay their contribution for membership in the HMO through payroll deductions. The Committee believes that employer obligations in this regard should be specified in title XIII.

The ability of employees to make through payroll deductions any contribution required of them for membership in an HMO is essential if employees are to choose freely between HMOs and health services or health insurance plans and if HMOs are to efficiently administer their programs. With payroll deductions the HMO can send one statement to the employer for all enrolled employees. Without payroll deductions each employee would be responsible for paying for membership and the HMO would be responsible for collecting contributions for membership from each employee. The Committee believes that placing this additional burden on employees makes the HMO option less attractive and thus defeats the underlying and original purposes of section 1310.

The Committee's proposal clarifies this aspect of existing law by requiring certain employers to provide for payroll deduction. This requirement would apply to employers who are required by section 1310 (a) to offer their employees the option of membership in qualified HMOs and which either provide payroll deduction as a means of paying employees contributions for health benefits (other than in an HMO) or provide a health benefits plan for which an employee contribution is not required. Any such employer must, upon request of employees who exercise the option of membership in a qualified HMO, arrange for any contribution required of such employees for such membership to be made through payroll deductions.

The Committee believes that this new requirement will not impose an undue administrative burden or expense on employers. The General Accounting Office in its June 30, 1978 report to Congress stated that 187 employers contacted by the GAO reported no significant effect on their costs resulting from offering membership in an HMO.

Funding under other authorities for the provision of health services on a prepaid basis (section 8)

Section 1313 of the Public Health Service Act prohibits the use of funds appropriated under the Public Health Service Act other than those appropriated under title XIII for developing HMOs. This provision was directed at preventing the practice by HEW in the early 1970's of using other authorities to support HMO development.

The Committee's amendment provides an exception to this prohibition. It would allow funds appropriated under sections 319 and 330 of the Public Health Service Act to be used by a migrant health center or a community health center to plan for and develop or to provide a *portion* of their health services on a prepaid basis. If, however, such a center intended to become an HMO providing *all* services on a prepaid

basis, the center would have to seek funding under title XIII and would not be permitted by this amendment to seek funds under sections 319 or 330 for such activities.

The Committee recognizes that migrant health centers and community health centers need flexibility in providing services. It might be appropriate as well as financially advantageous for those centers to provide health services on a prepaid basis to only a portion of their service populations. For example, a comunity health center in a small community operating on a fee-for-service basis might choose to provide services on a prepaid basis to the employees of the two small industrial companies in its service area.

Loans and loan guarantees for acquisition and construction of ambulatory health care facilities (section 9)

One of the most important cost saving features of HMOs is their use of ambulatory health care services. Thus, the suitability, convenience and attractiveness of the HMO's ambulatory facilities are critical to its success. M'ost HMOs in their early years of operations do not have access to sufficient capital to acquire or construct new ambulatory health care facilities. There are several reasons for this lack of access. First, HMOs which are Federally assisted may not use initial development grants for the construction or acquisition of facilities. (They may, however, use them for renting and renovating facilities). Second, HMOs which are Federally assisted are required, as a condition of receiving a loan or loan guarantee for the costs of operations, to commit all membership revenues to the payment of operating costs such that the loan covers only the operating cost deficit. Third, virtually all developing HMOs, whether Federally assisted or not, are either in a financial deficit position or have an inadequate equity base and financial record and have great difficulty in attracting capital from the private financial community. Finally, the existing loan programs under title XVI of the PHS Act and under the Federal Housing Authority of the Department of Housing and Urban Development have not met the needs of HMOs. The loan program under title XVI is for the construction of new outpatient medical facilities, but no funds have been appropriated for this purpose because the Department of Health, Education, and Welfare has failed to promulgate regulations which would allow the program to be implemented.

Also, because the determination of an HMO's ability to repay the construction loan and the continuing monitoring of the HMO's fiscal soundness could only be performed by the HMO program staff, it would be inappropriate for decisions regarding loans and loan guarantees for construction to be made in a branch of HEW not familiar with HMO requirements and could possibly jeopardize the interest of the United States in the repayment of such loans. The loan program under the Federal Housing Authority, carried out pursuant to Title XI of the National Housing Act, provides support for construction of multi-specialty clinics, but imposes requirements regarding the number of physicians in specialities which are inappropriate for small, developing HMOs. Also, even though HEW administers portions of the FHA loan program, it is again counterproductive to have a separate branch of HEW or the Federal Housing Authority making decisions about construction loans for HM'Os.

All developing HMOs must make timely plans to accommodate membership increases. The unavailability or uncertainty of financing for construction seriously impinges on this planning process. This often results in costly delays in acquiring new facilities or worse, in an inability to meet the needs of expanding membership. In either event, HMO development is frustrated.

In order to insure that the necessary resources are available in a timely manner, the Committee's bill adds a new section to title XIII to allow the Secretary to (1) make loans, from the existing loan fund established under section 1308(e), to public and nonprofit private HMO's for projects for the acquisition or construction of ambulatory health care facilities or for the acquisition of equipment for facilities acquired or constructed, and (2) guarantee the payment of principal and interest to non-Federal lenders for their loans and the Federal Financing Bank for its loans to nonprofit private health maintenance organizations for projects described in this sentence and to private for-profit HMO's for similar projects which will serve medically underserved populations. The aggregate amount of principal of loans made or guaranteed under the authority of this new section for HMOs may not exceed $2.5 million. The term "ambulatory health care facility" means a health care facility for the provision of diagnostic, treatment, and preventive services to ambulatory patients.

Loans made or guaranteed could be (1) for the acquisition of ambulatory health care facilities and the equipment for such facilities; and (2) for the (a) construction of new ambulatory health care facilities, (b) alteration, expansion, remodeling, replacement or renovation of existing ambulatory health care facilities, (c) cost of off-site improvements in connection with an activity described in (a) or (b), (d) cost of the acquisition of land in connection with the activities described in (a), (b), or (c), and (e) acquisition of equipment in connection with the activities described in (a) or (b).

The Secretary of HEW is authorized to take such actions as are deemed appropriate to protect the interest of the United States in the event of a default on a loan made or guaranteed under title XIII (including taking possession of, holding, and using real property placed in security for such a loan or loan guarantee).

The Committee recognizes that this new loan program is a substantial increase in the loan support available to HMOs. Because ambulatory facilities are so important to the success of HMOs, the committee believes the new loan support is warranted. However, the Committee has included several provisions to insure that the new loan support is used appropriately. The cumulative total of the principal of loans outstanding at any time which have been directly made or guaranteed may not exceed the limitations specified in appropriation Acts; so even though these new loans will be made from the existing loan funds, appropriation Acts may set a separate limit on the total amount of loans outstanding for construction purposes just as they may specify under section 1305(b)(2) the cumulative total of the principal of loans outstanding for initial operating costs.

Second, because these loans will only be available to qualified HMO's HEW will be able to evaluate each HMO's past and current financial position as well as its ability to repay the loan. The Committee is satisfied that the problems which have plagued the HMO loan pro-

gram, as pointed out by the GAO in its June 30, 1978 report to the Congress, are being corrected. The Department plans to substantially increase the number of individuals performing compliance activities, thereby improving the ability of the HMO program to evaluate an HMO's fiscal soundness and potential to repay any loan for the construction or acquisition of a facility. To assure that these and other changes in the administration of the loan program to which the Department has committed itself are carried out, the Committee has asked the GAO to monitor these changes and to report to the Committee no later than November 15, 1978.

And third, the requirements of section 1306(b)(2), which allow the Secretary to make or guarantee loans only to those applicants who would not be able to complete their projects without such assistance, will apply to loans and loan guarantees made under this new section.

The Committee has been advised by HEW that approximately 32 of the 63 currently qualified HMO's may need loans for the construction of new ambulatory facilities during the next five to seven years.

Training and technical assistance (section 10)

Testimony before the Committee's Subcommittee on Health and the Environment confirmed that the lack of qualified managerial personnel is a major impediment to HMO growth. The GAO also singled out this shortcoming as one of the most common reasons for financial difficulties among developing HMOs.

The Committee reponded to this problem by authorizing the Secretary to establish a "National Health Maintenance Organization Intern Program" for the purpose of providing special training for individuals who wish to become administrators, medical directors or assume other managerial positions with HMOs. The Committee's purpose in authorizing this program is to provide training to individuals with all or nearly all of the necessary skills to assume managerial positions in an HMO, but who need to adapt their skills to the particular managerial problems of HMOs. The Committee expects the internship to emphasize practical experience in an HMO at the location of the HMO. The Committee recognizes that it might be appropriate to supplement such onsite training with academic training at an educational institution; but such academic training and the involvement of educational institutions should be secondary to the activities occuring onsite at the HMO.

Internships under the program could provide for stipends and allowances (including travel and subsistence expenses and dependency allowance) for the recipient of the internship to the extent deemed necessary by the Secretary. The Secretary may also provide payments to HMOs or to other entities for the cost of support services (including the cost of salaries, supplies and related items) provided such individual by the HMO or other entity. The amount of these payments would be determined by the Secretary and would bear a direct relationship to the reasonable costs of the organization or entity for the activities they perform in the training program.

The Committee expects the Secretary to evaluate carefully any costs of an organization or other entity which are described as indirect or overhead costs and to insure that those costs are reasonable and associated with the training program.

In response to this concern that HMO management needs strengthening and in response to the difficulty inherent in HMO development, the Committee has also provided specific authority for technical assistance to (1) entities engaged in surveys or other activities to determine the feasibility of developing and operating or expanding the operation of an HMO, (2) entities engaged in the planning for the initial development of HMOs, (3) entities engaged in initial development of HMOs, and (4) HMOs in connection with their operation. The Secretary would be authorized to provide this assistance either directly or through grants and contracts with other entities. The Committee notes that limited technical assistance has been provided using program management funds. This provision is designed to assure that this effort is continued and strengthened.

The Committee did not for the Intern Program or for the provision of technical assistance. The Secretary may obligate funds for the provision of training and technical assistance from the appropriations made pursuant to the authorizations for grants and contracts under section 1309(a).

Administration of program (section 11)

Section 1312(c) requires that functions relating to the continued regulation of HMOs be administered in the Office of the Assistant Secretary for Health. Section 1310(h) requires that the duties and functions involved in making determinations as to whether an organization is a qualified HMO be administered through the Office of the Assistant Secretary for Health and be integrated with the administration of the continued regulation of HMOs (section 1312(c)). The Committee believes that these restrictions on the location within the Department of Health, Education, and Welfare of these functions of the HMO program are unnecessary. As long as the duties and functions regarding the determination of whether an organization is a qualified HMO are integrated with the function of continued regulation, the Committee believes that the Secretary of HEW should have flexibility in determining the proper administrative location of the HMO program. The Committee proposal would amend section 1310(h) and repeal section 1312(c) to provide the Secretary with such flexibility.

Disclosure of ownership and related information (section 12)

As noted earlier, the report of the Permanent Subcommittee on Investigations of the Senate Committee on Governmental Affairs on prepaid health plans and HMOs outlines inappropriate practices which occurred in the prepared health plans in California and which might occur in any HMO. The potential for such inappropriate practices, which are fraudulent or otherwise not in the interest of HMO members, is of serious concern to this Committee. The Committee also notes, however, that in seeking to prevent such inappropriate practices there is a danger of stifling the development of HMOs and of discouraging private investment in them.

The Committee believes that the appropriate approach to resolving this problem is not to place restrictions on the management practices of HMOs or to specifically enumerate management practices which are prohibited. Instead, there should be requirements for (1) reports con-

taining relevant information, such as the names of persons with an ownership or control interest in the HMO, (2) assurances that the HMOs transactions which have the potential of adversely affecting the HMO are in fact in the interest of the HMO, and (3) reports, available to the Secretary of the Department of Health, Education, and Welfare which describe such transactions and which allow the Department of Health, Education, and Welfare to examine their effect on the HMO. The Committee has designed reporting requirements which are not overbearing and which do not presume wrongdoing on the part of HMOs. The Committee notes that indeed some transactions between HMOs and a party in interest may accrue significant benefits to the HMO. The intent of the Committee is to require reporting by HMOs and monitoring of those reports and the performance of the HMO by the Department of Health, Education, and Welfare in order to assure that no transactions between the HMO and a party in interest are unfavorable to the HMO.

The Committee's proposal provides for three new disclosure requirements and new assurances from each HMO which is qualified under section 1310(d). The first reporting requirement is that each HMO must, in accordance with regulations promulgated by the Secretary, provide the information required to be reported by disclosing entities under section 1124 of the Social Security Act, and supply the information required to be supplied under Section 1902(a)(38) of the same Act. Section 1124 requires each disclosing entity to supply the Department of Health, Education and Welfare with full and complete information as to the identity of each person with an ownership or control interest in the disclosing entity or in any subcontract in which the disclosing entity directly or indirectly has a 5 percent or more ownership interest. A person with an ownership or control interest means, with respect to the disclosing entity, a person who (1) has directly or indirectly an ownership interest of 5 percent or more in the disclosing entity or is the owner (in whole or in part) of an interest of 5 percent or more in a mortgage, deed of trust, note or other obligation secured (in whole or in part) by the disclosing entity or any of the property or assets of the disclosing entity; or (2) is an officer or director of the disclosing entity, if the disclosing entity is organized as a corporation; or (3) is a partner in the disclosing entity, if the disclosing entity is organized as a partnership. Section 1124 also requires, to the extent determined to be feasible under regulations of the Secretary, a disclosing entity to include in the information supplied with respect to each person with an ownership or control interest in the disclosing entity, the name of any other disclosing entity with respect to which that person is a person with an ownership or control interest.

Section 1902(a)(38) requires that an entity supply, within such period as may be specified in regulations by the Secretary, (1) full and complete information as to the ownership of a subcontract or with whom such entity has had, during the previous 12 months, business transactions in an aggregate amount in excess of $25,000 and (2) full and complete information as to any significant business transactions, occurring during the five-year period ending on the date of such request, between such entity and any wholly owned supplier or between such entity and any subcontractor.

The second reporting requirement is that each HMO must file with the Secretary, at such times as the Secretary shall prescribe, such

information as the Secretary may require to demonstration that the HMO has a fiscally sound operation. Section 1310(d) requires the Secretary, in determining whether the HMO is a qualified HMO, to determine that the HMO is organized and operated in the manner prescribed in section 1301(c). Section 1301(c)(1) requires each HMO to have a fiscally sound operation. This new reporting requirement makes explicit the authority of the Secretary to require an HMO, in order to obtain or retain qualification, to provide such information to the Secretary as is necessary to demonstrate that the HMO has a fiscally sound operation.

The third reporting requirement of the bill is that each HMO must file with the Secretary, at such times as the Secretary shall prescribe, such information as the Secretary may require respecting transactions with parties in interest. Transactions included in this reporting requirement include (1) any sale, exchange or leasing of any property between the organization and a party in interest, (2) any furnishing by the organization of services to a party in interest and any furnishing of services to the organization by a party in interest, and (3) any lending of money or other extension of credit between the organization and the party in interest. The term "party in interest" means (1) a person with an ownership or control interest (as defined in section 1124(a)(3) of the Social Security Act, and as described above) in the HMO, (2) a managing employee (as defined in section 1126(b) of such Act) of the organization (section 1126(b) defines the term "managing employee" as an individual, including a general manager, business manager, administrator, and director, who exercises operational or managerial control over the institution, organization, or agency, or who directly or indirectly conducts the day to day operations of the institution, organization, or agency), (3) an entity with respect to which an individual described in clauses (1) or (2) above is a person with an ownership or control interest or a managing employee, and (4) any member of the immediate family of an individual who is a person described in clause (1) or (2) above.

The Committee's bill includes several provisions to insure compliance with these reporting requirements. First, an HMO may not be qualified under section 1310(d) unless (1) it provides to the Secretary the reports required by this section, (2) it provides to the Secretary satisfactory assurances that the terms of each transaction between the HMO and a party in interest will be at least as favorable to the HMO as if the transaction was between the HMO and a person who is not a party in interest, and (3) it makes available to its members the information it reports to the Secretary pursuant to these reporting requirements. Second, each entity which seeks Federal financial assistance must provide assurances satisfactory to the Secretary that it will comply with these reporting requirements. And third, the Secretary in carrying out the continued regulation of HMO's under section 1312 must determine if HMO's, which either receive Federal financial assistance or are qualified under section 1310(d), are meeting these reporting requirements.

The Committee's proposal provides the Secretary of HEW with broad discretion as to when the information required to be reported is provided to the Secretary. Each type of information would be reviewed for different purposes and at different times in the evaluation of the HMO's performance. Information regarding an HMO's owner-

ship and control, for instance, might be filed upon application for qualification and subsequently upon any change in its ownership and control relationships, while information regarding transactions with parties in interest might be required to be available upon HEW's request without any requirement of annual filing. The Committee has left the appropriateness of the filing requirements to be determined by the Secretary so that each reporting requirement can be tailored to take action against activities by the management of or parties in interest in the HMO which adversely affect the HMO. In making such determinations, the Secretary should balance the burden which such requirements place on HMO's against the usefulness of the data collected.

The Secretary is required to include in the annual report (required by section 1315) a summary of analyses of the information provided pursuant to these reporting requirements and a description of any action taken as a result of such evaluations.

Amendments to the Social Security Act (Section 13)

Conflict of interest

The Committee's bill includes two amendments to the Social Security Act. The first deals with the activities of State and local officers and employees who are responsible for the expenditure of substantial amounts of funds under the State Medicaid program.

The Committee believes that sections 207 and 208 of Title 18 of the United States Code, provide reasonable restrictions on the activities of current and former officers and employees of the executive branch of the United States Government in order to prevent conflicts of interest on the part of those officers and employees. These restrictions protect the interest of the United States Government as well as the integrity of the Agency or program for which the officers or employees work. The Committee's proposal amends title 19 of the Social Security Act to extend these restrictions to (1) State and local officers and employees who are responsible for the expenditure of substantial amounts of funds under the State medicaid plan (2) to each individual who formerly was such an officer or employee and (3) to each partner of such an officer or employee. By extending these restrictions to these State and local officers and employees, the Committee believes that the interest of State and local governments and the integrity of the State Medicaid plans will be protected against conflicts of interest on the part of those State officers and employees.

Section 207 prohibits any former officer or employee of the executive branch of the Federal government from (1) acting as agent or attorney for anyone other than the United States in matters connected with their former duties or official responsibilities in which such person participated personally and substantially, or (2) appearing personally before any court or Federal government agency as agent or attorney for one year for anyone other than the United States in connection with any matter which was under such person's official responsibility within one year prior to terminating such responsibility. Section 207 also prohibits any partner of an officer or employee from acting as agent or attorney for anyone other than the United States in matters in which such officer or employee participates or has participated or which are the subject of his official responsibility. Section 208 prohibits an officer or employee of the United States from participating in matters in

which he, his family, partner or any organization with which he is associated has a financial interest.

REVIEW OF CAPITAL EXPENDITURES

The reported bill amends section 1122 of the Social Security Act, which deals with the review of proposed capital expenditures by planning agencies and subsequent reimbursement by the medicaid and medicare program. The amendment would require that HMO's be covered equally with other health care entities or organizations under this review program. Under current law, an HMO is subject to requirements which could promote discrimination against HMO's. Specifically, the establishment of an HMO and its development of outpatient facilities and services currently are required to be covered, while similar noninstitutional services are not. The reported bill seeks to eliminate this discrepancy.

EMPLOYEES' HEALTH BENEFIT PLANS (SECTION 14)

The Committee has been encouraged by the active involvement of Blue Cross/Blue Shield and commercial insurance carriers in the support and development of HMO-like plans. The Committee is also pleased with the commitment which these organizations have made to continue that activity and augment Federal HMO developmental efforts. However, the Committee was advised by Blue Cross/Blue Shield that many of its plans have been operating various alternative health care delivery systems for several years—which they developed with their own resources and managerial talents—but which cannot be qualified as health maintenance organizations primarily because of the provisions of section 1301(c)(6) requiring that one-third of the governing board be composed of HMO members. These alternative delivery systems are operated as a line of business of the Blue Cross/Blue Shield plans, rather than through a separate legal entity, and are subject to the overall supervision and control of the Blue Cross/Blue Shield Board of Directors.

A provision is included in the bill which would deal with this problem by granting the Secretary discretionary authority to waive the provisions of section 1301(c)(6) for commercial insurance carriers or nonprofit carriers which provide hospital service benefits or medical or surgical benefits, or both, and which on July 1, 1978 were operating an HMO as defined in regulations developed pursuant to section 1122 of the Social Security Act). In all other respects, the plan would be required to meet the organization, operational and other requirements of Title XIII. The waiver would be granted only on such terms and conditions as the Secretary may determine are appropriate. Among other requirements, these may include controls and assurances such as: the right of the HMO's management to develop or arrange for independent marketing efforts and/or to enroll members directly and not exclusively through Blue Cross/Blue Shield; assurances that dual choice provisions of the HMO Act will not be used to market other lines of business; separate accounting for the HMO line of business and other controls designed to assure accountability and as competitive a premium structure as possible; to the extent permitted by state

law, the establishment of a policymaking body charged only with a fiduciary obligation to protect and enhance the best interests of the HMO and its members; and other conditions, controls and assurances the Secretary may deem appropriate to ensure maximum competition between HMO's and more traditional lines of insurance, as well as between and among existing prepaid plans and those likely to develop in the marketplace. In addition, the Committee expects the Department to require some mechanism, such as an advisory board, to assure that HMO members have the opportunity to influence the policies of the HMO.

The Committee expects the Secretary to exercise this discretionary authority in a manner calculated to ensure that competition is intensified, rather than diminished, in the health care market. For this reason, the Committee urges that HEW holds a public hearing with adequate notice as to place, time and comment procedures on application each for a waiver under this section, and that HEW carefully evaluate the hearing record and such other information that may come to its attention regarding any such application. It is expected that during this review HEW will closely scrutinize such factors as how the plan proposes to coordinate and/or separate its prepaid and more traditional marketing activities.

The Committee was concerned about the possible competitive consequences of permitting an HMO, operated as a line of business of a carrier that is primarily engaged in selling a competing kind of coverage, to occupy a dual choice slot under section 1310. This section of the bill therefore provides the Secretary with discretion to require that employers offer two HMO's of the same type as the one qualified with this waiver when two or more plans are or become available in the same service area. A separate determination regarding the applicability of this "triple choice" requirement will be made at the time of the initial waiver determination and of each service area expansion. This authority is provided to foster competition and to ensure the development and the viability of competing HMO's in areas where Blue Cross/Blue Shield controls a considerable share of the fee-for-service market.

It is anticipated that approximately 14 Blue Cross/Blue Shield plans may be eligible to apply for a waiver under these provisions, seven of which commenced HMO-like operations prior to passage of the original HMO Act in 1973 and seven of which started to enroll members and deliver prepaid health services after passage of that Act but prior to July 1, 1978. Because this is viewed as a one-time waiver intended to correct an anomolous situation which developed before the provisions of the 1973 Act were known and before the desirability of qualification under section 1310 became clear, plans seeking to take advantage of such a waiver must notify the Secretary of their intent to apply for qualification as a health maintenance organization within 180 days of enactment and must actually file their qualification application indicating their conformity with all requirements of Title XIII (other than section 1301(c)(6)) within 18 months of enactment. Since the purpose of the waiver is to protect preexisting private investment and efforts, no plan is eligible for a waiver if the HMO-like project ever received Federal financial assistance; nor will any plan so qualified be eligible for Federal financial assistance, including loans and loan guarantees.

The Committee does not intend this waiver provision to modify in any way the requirements of qualification under section 1310 for Blue Cross/Blue Shield HMO-type plans not already fully operational, enrolling members and providing service by July 1, 1978.

DISCRIMINATION AGAINST HEALTH MAINTENANCE ORGANIZATIONS

The Committee has received a number of complaints from HMO's claiming that hospitals have discriminated against HMO's through denial of staff privileges to HMO physicians or by refusing to negotiate in good faith for hospital services. The Committee is concerned that such practices can be seriously hinder orderly HMO growth and development.

During the deliberations in the 93rd Congress the Committee considered legislation which would make it illegal for States to permit hospitals to discriminate against HMO's in offering their services or staff privileges. The Committee did not adopt this proposal at that time partly in the hope that hospitals would cooperate with HMO's as they developed and were better understood.

While there is no present intention to re-examine such provisions, the Committee does direct HEW to carefully review and study the question of hospital relationships with HMO's and, if warranted, submit specific legislative recommendations for consideration by the Congress. The Department should include in its study an examination of the need to require a hospital to quote an annual prospective rate to a qualified HMO. The Committee expects that HEW in carrying out this study will use the authority of the Inspector General to investigate cases of unlawful hospital discrimination against HMO's.

VII. Program Oversight

The Committee's principal oversight activities with respect to this program have been conducted by the Subcommittee on Health and the Environment in connection with its consideration of the legislative authorities for this program. Legislative hearings were held on June 30, 1978. The Committee has been assisted in this activity by the General Accounting Office, which was required by section 1314 of The Public Health Service Act to evaluate the HMO program. A report was prepared and submitted to the Congress on June 30, 1978 in response to this requirement. The findings of the committee's oversight activities are discussed in this report under "committee proposal," as the proposed legislation is designed to respond to the Subcommittee findings.

The Committee has not received reports from either its own Subcommittee on Oversight and Investigations or the Committee on Government Operations.

VIII. Inflation Impact Statement

The Committee anticipates that the enactment of H.R.13655 will have a beneficial impact on inflation by reducing the rate of increase in medical care costs. Recent studies indicate that HMO's are generating substantial savings to their members. Because HMO's have a financial incentive to keep their members well, and because HMO's have

been successful in reducing the rate of hospitalization for their members, HMO's have generated cost savings of 10% to 40%.

In fiscal year 1978, the HMO program is still a relatively small program. The small increases in authorizations for this program for fiscal years 1980 and 1981 will develop additional HMO's; but the Committee expects that each HMO will play a significant role in reducing the rate of increase in medical care costs for the members enrolled in that HMO. The Committee also expects that HMO's will compete with the fee for service system and with other forms of health insurance on the basis of price. Such competition will play an important role in restraining the rate of increase in the costs of all health providers and in the premiums charged by other forms of health insurance. By fostering this competition this legislation will have a beneficial impact on the rate of inflation in medical care costs.

IX. Congressional Budget Office Cost Estimate

A cost estimate was requested on H.R. 13655 when it was ordered reported from the Committee on Interstate and Foreign Commerce, and the Congressional Budget Office has provided the following information:

U.S. Congress,
Congressional Budget Office,
Washington, D.C., August 11, 1978.

Hon. Harley O. Staggers,
Chairman, Committee on Interstate and Foreign Commerce,
U.S. House of Representatives,
Washington, D.C.

Dear Mr. Chairman: Pursuant to Section 403 of the Congressional Budget Act of 1978, the Congressional Budget Office has prepared the attached cost estimate for H.R. 13655, a bill to amend the Public Health Service Act to revise and extend the program of assistance under that Act for health maintenance organizations.

Should the Committee so desire, we would be pleased to provide further details on the attached cost estimate.

Sincerely,

Alice M. Rivlin, *Director.*

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

1. Bill No.: H.R. 13655.
2. Bill title: Health Maintenance Organization Amendments of 1978.
3. Bill status: As ordered reported by the Committee on Interstate and Foreign Commerce on August 8, 1978.
4. Bill purpose: To amend the public Health Service Act in order to revise and extend the program of assistance under that Act for health maintenance organizations (HMOs). The bill extends the program of grants for feasibility studies, planning, and initial development of HMOs. It raises the limit on loans that can be made to HMOs to cover the costs of operation. It also provides that loans and loan guarantees can be made for construction projects. The bill also es-

tablishes a National Health Maintenance Organization Intern Program and specifies additional requirements for the manner of operation of HMOs.

5. Cost estimate:

[By fiscal year, in millions of dollars]

Authorization level (grants and contracts):	
Fiscal year:	
1979	0.0
1980	63.0
1981	63.0
1982	0.0
1983	0.0
Projected costs (grants and contracts):	
Fiscal year:	
1979	0.0
1980	60.2
1981	62.7
1982	2.8
1983	0.3

The costs of this bill fall within budget function 550.

6. Basis of estimate: The amounts authorized in the bill are assumed to be fully appropriated in each fiscal year. The yearly costs were derived by applying the historical spendout rates for the program to the authorized amounts.

The bill also provides that loan guarantees may be made by the Secretary of HEW for construction of ambulatory health care centers. HEW has estimated that about 32 HMOs will expand to the extent that new facilities will be needed in the next five to seven years. On the assumption that five HMOs will seek private construction loans of $2.0 million in each of the next five fiscal years, it is estimated that the contingent financial liabilities of the federal government will increase by about $50.0 million. It is assumed on the basis of the experience of the program to date that the default rate on these construction loans will be negligible.

7. Estimate comparison: None.

8. Previous CBO estimate: None.

9. Estimate prepared by Eric Wedum.

10. Estimate approved by James L. Blum, Assistant Director for Budget Analysis.

X. Agency Reports

Agency reports were requested on H.R. 13266, a similar predecessor to H.R. 13655, on June 30, 1978 from the Office of Management and Budget and the Department of Health, Education, and Welfare.

No reports had been received when this report was filed.

XI. Section-by-Section Analysis

The purpose of this bill is to amend the Public Health Service Act to revise and extend the program of assistance under that Act for health maintenance organizations.

Section 1. Short title, reference to act

Section 1 contains the short title of the bill.

Section 2. Extension of program

Section 2 amends sections 1304(j) and 1305(d) to extend the authority to provide support to entities which desire to become health maintenance organizations and to health maintenance organizations. It amends section 1309(a) to extend the authorizations of appropriations for the making of grants and contracts under sections 1303, 1304(a), 1304(b), and new section 1317 at a level of $63 million in FY 1980, and $63 million in FY 1981. It also extends authority to make loans under section 1305(d) through September 30, 1981.

Section 3. Requirements for the provision of services

Section 3(a) amends section 1301(b)(1) to permit a health maintenance organization to seek reimbursement for the cost of services provided to a member who is entitled to benefits under a workmen's compensation law or an insurance policy.

Section 3(b) amends section 1301(b)(3) to allow an HMO up to five years to reduce its reliance on contracts with physicians other than staff physicians or those who are not in medical groups or individual practice associations. At any time the amount paid to such physicians could not exceed 50 percent of the total amount paid for the services of physicians and in the fifth and succeeding years the amount could not exceed 15 percent (30 percent in rural areas). The restriction in existing law applies to contracts with all health professionals and entities other than medical groups an individual practice associations.

Section 3(c) amends section 1301(b)(4) by removing the financial responsibility of an HMO for services provided by another organization to a member of the HMO if the member intentionally left the area served by the HMO for the purpose of securing those services.

Section 3(d) amends section 1301(b) to provide that a health maintenance organization is only required to make a good faith effort to provide health services in the event that disaster, war or other occurrences beyond its control prevent it from providing service in accordance with the Act.

Section 3(e) amends section 1302(1) to provide that an HMO is not required to provide services which the Secretary determines to be unusual or infrequently provided and are not necessary for the protection of individual health.

Section 4. Organization requirements

Section 4(a) amends section 1301(b) by allowing the HMO to provide services to full-time students at an accredited institution of higher education for a payment that is not fixed under a community rating system.

Section 4(b) requires that an HMO has certain administrative and managerial arrangements and capabilities.

Section 4(c) amends section 101(c)(3) to require HMOs to carry out enrollment activities of Title XIX beneficiaries in accordance with procedures developed by the Secretary in regulations. This is designed to curtail certain abuses in the marketing of HMOs.

Section 4(d) amends section 1301(c)(6) to exclude public HMOs from the requirements that at least one-third of the membership of the policy making body of an HMO be members of the organization

and that the body include equitable representation from medically underserved populations served by the organization. Under the amendment a public HMO must have an advisory board which meets these requirements. This board may be delegated policy authority for the organization.

Section 5. Feasibility surveys and initial development

Section 5(a) amends section 1306(b)(2) to allow support for HMO feasibility studies regardless of the financial position of the applicant; all other support would be provided to organizations only if the applicant would not be able to complete the project without Federal assistance.

Section 5(b) and (c) amends section 1304(b) to modify the support available to organizations for initial development. An HMO would continue to be eligible to receive up to $1 million to support its establishment and it would be eligible to receive up to $600,000 to support each significant expansion of membership or area served. A grant awarded under this section would be available for up to three years.

Section 6. Costs of operation

Section 6 amends section 1305 to expand the support which may be provided to an HMO for its initial costs of operation. An aggregate amount of $4 million of loans or loan guarantees would be available to an HMO for this purpose. This support would include capital costs such as the cost of acquiring equipment. Existing law precludes the use of loans to acquire equipment. In any one year an HMO would be limited to $2 million of loan or loan guarantee support.

Section 7. Payroll deductions for health benefits

Section 7 amends section 1310(c) so that each employer which provides payroll deductions as a means of paying employees' contributions for health benefits or which provides a health benefits plan to which an employee contribution is not required and which is required to offer his employees the option of membership in a qualified health maintenance organization will be required to arrange, upon request of an employee who exercises such option, for the employee's contribution for such membership to be paid through payroll deductions.

Section 8. Funding under other authorities for the provision of health services on a prepaid basis

Section 8 amends section 1313 to allow funds under sections 319, "Migrant Health," and 330, "Community Health Centers," of the Public Health Service Act to be used for grants to migrant and community health centers (which centers are not HMO's) for the planning and development of health services to be provided on a prepaid basis or for the provision of health services on a prepaid basis.

Section 9. Loans and loan guarantees for acquisition and construction of ambulatory health care facilities

Section 9 adds a new section after section 1305 to provide loans and loan guarantees to qualified health maintenance organizations for the acquisition and construction of ambulatory health care facilities and for the acquisition of equipment for facilities acquired or constructed. The Secretary may make loans to public and nonprofit private

health maintenance organizations; and the Secretary may guarantee the payment of principal and interest on loans made by non-Federal lenders and the Federal Financing Bank to nonprofit private health maintenance organizations and to private health maintenance organizations for projects which serve medically underserved populations. The aggregate amount of principal of loans made or guaranteed under this section may not exceed $2.5 million dollars. The authority of the Secretary to make loans is effective for any fiscal year only to the extent or in the amounts as are provided in advance in appropriation Acts. The term "construction" means (1) construction of new facilities, (2) alteration, expansion, remodeling, replacement and renovation of existing facilities, (3) cost of off-site improvements in connection with any activity described in (1) or (2), and (4) cost of the acquisition of land in connection with an activity described in (1), (2) or (3). The Secretary is authorized to take such actions as he deems appropriate to protect the interest of the United States in the event of a default on a loan or loan guarantee made under this section or the other relevant sections of Title XIII.

Section 10. Training and technical assistance

Section 10 adds a new section 1317 to require the Secretary to establish a National Health Maintenance Organization Intern Program for the purpose of providing training to individuals to become administrators and medical directors of health maintenance organizations or to assume other managerial positions with health maintenance organizations. The Secretary may provide these internships directly or may make grants to or enter into contracts with health maintenance organizations and other entities to provide the internships. The program will provide stipends and allowances (including travel and subsistence expenses and dependency allowances) for the recipients of the internships and grants and contracts to health maintenance organizations and other entities for the cost of support services (including the cost of salaries, supplies, equipment and related items) provided to recipients of the internships by the organization or the entity. The amount of any payment to an organization or an entity shall be determined by the Secretary and shall bear direct relationship to the reasonable cost of the organization or entity for establishing and maintaining the training program. Funds for these internships are provided in the authorizations of appropriations in section 1309(a). The authority of the Secretary to enter into contracts under this section shall be effective for any fiscal year only to the extent or in the amounts as are provided in advance for appropriation Acts. This section shall be effective for fiscal years on or after October 1, 1979.

Section 11. Administration of program

Section 11 amends section 1310(h) and repeals section 1312(c). These changes delete the requirement that the qualification and compliance functions be located in the Office of the Assistant Secretary for Health.

Section 12. Disclosure of ownership and related information

Section 12 amends section 1310(d) to provide that all qualified health maintenance organizations (1) must provide the Secretary

with ownership and related information, (2) must provide the Secretary with assurances satisfactory to the Secretary that the terms of each transaction between the health maintenance organization and a party in interest will be at least as favorable to the health maintenance organization as if the transaction was between the health maintenance organization and a person who was not a party in interest, and (3) must make available to its members the information reported by the organization pursuant to (1) and (2). The ownership information required is identical to that required by section 1124 and 1902(a)(38) of the Social Security Act (added by P.L. 95–142, the Medicare-Medicaid Anti-Fraud and Abuse Amendments). The related information which may be required by the Secretary, at such time as the Secretary shall prescribe, is information (1) to demonstrate that the health maintenance organization has a fiscally sound operation and (2) respecting any transaction between the health maintenance organization and a party in interest. The term "party in interest" means (1) a person with an ownership or control interest (as defined in section 1124(a)(3) of the Social Security Act) in the health maintenance organization, (2) a managing employee (as defined in section 1126(b) of the Social Security Act) of the organization, (3) any entity with respect to which an individual described in (1) or (2) is a person with an ownership or control interest (as so defined) or managing employee (as so defined), and (4) any member of the immediate family of an individual who is a person described in (1) or (2). This section also requires the Secretary to include in the annual report required by section 1315 a summary of evaluations made of the information and a description of any action taken as a result of such evaluation.

Section 12 also amends section 1306(b) to require that an application for a grant, contract, loan or loan guarantee under Title XIII contain assurances satisfactory to the Secretary that the organization will comply with the requirements added to section 1310(d) by section 12 of the bill.

Section 12 also amends section 1312(a) to require the Secretary to take the actions authorized by section 1312(b) if he determines that an entity which received a grant, contract, loan or loan guarantee under Title XIII as a health maintenance organization or which was included in the health benefits plan offered to employees pursuant to section 1310, fails to meet the requirements added to section 1310(d) by section 12 of this bill.

Section 13. Amendments to the Social Security Act

Section 13(a) extends the prohibitions of sections 207 and 208 of title 18, United States Code, to State or local officers or employees who are responsible for the expenditure of substantial amounts of Medicaid funds, to each individual who formerly was such an officer or employee and to each partner of such an officer or employee.

Section 207 prohibits former officers and employees of the executive branch of the federal government from (1) acting as agent or attorney for anyone other than the United States in matters connected with their former duties or official responsibilities in which they participated personally and substantially, or (2) appearing personally before

any court or federal government agency as agent or attorney for one year for anyone other than the United States in connection with any matter which was under their official responsibility within one year prior to terminating such responsibility. Section 207 also prohibits partners of an officer or employee from acting as agent or attorney for anyone other than the United States in matters in which such officer or employee participates or has participated or which are the subject of his official responsibility. Section 208 prohibits an officer or employee of the United States from participating in matters in which he, his family, partner or any organization with which he is associated has a financial interest.

Section 13(b) amends Section 1122 of the Social Security Act to provide that HMOs would be covered equally with other health care entities under this program of health planning agency review of capital expenditures.

Section 14. Employee's health benefits plans

Section 14 amends section 1310(d) to include as a qualified health maintenance organization certain entities which have received a waiver of the requirements of section 1301(c)(6) and which meet all other requirements prescribed by section 1301 (b) and (c) and the reporting requirements prescribed by section 1310(d) (which were added by section 12 of this bill). The Secretary of HEW may, upon application, grant a waiver to such entities upon such terms and conditions as the Secretary may determine are appropriate. Entities eligible to apply for this waiver must notify the Secretary of their intent to apply before the expiration of 180 days after the date of the enactment of this bill and must make their application before the expiration of 18 months after the date of enactment of this bill. An entity which receives this waiver may not receive a grant, contract, loan or loan guarantee under title XIII. Entities eligible to apply for a waiver are health maintenance organizations (as defined in regulations promulgated under section 1122 of the Social Security Act and in effect on the day before the date of enactment of this bill) (1) which are operated (but not as a separate legal entity) either by a commercial insurance carrier or a nonprofit carrier which provides hospital service benefits or medical or surgical benefits, or both, (2) with respect to which Federal financial assistance has not been provided under Title XIII, and (3) which on July 1, 1978 were engaged in providing basic health services (as defined in regulations promulgated under section 1122) to the organization's members. As a condition of approving the entity as a qualified health maintenance organization, the Secretary may alter the application of section 1310(b) to the service area of the entity.

The Secretary may require the health benefits plan of each employer subject to section 1310(a) which has at least 25 employees residing in the service area of the entity (which is the qualified health maintenance organization) to include in their employee's health benefits plan at least two qualified health maintenance organizations which provide service in the same service area in the same manner when at least two such organizations are willing to be included in the employee's health benefits plan.

XIII. Changes in Existing Law Made by the Bill, as Reported

In compliance with clause 3 of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black bracket, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

Public Health Service Act

* * * * * * *

TITLE XIII—HEALTH MAINTENANCE ORGANIZATIONS

REQUIREMENTS FOR HEALTH MAINTENANCE ORGANIZATIONS

Sec. 1301. (a) For purposes of this title, the term "health maintenance organization" means a legal entity which (1) provides basic and supplemental health services to its members in the manner prescribed by subsection (b), and (2) is organized and operated in the manner prescribed by subsection (c).

(b) A health maintenance organization shall provide, without limitations as to time or cost other than those prescribed by or under this title, basic and supplemental health services to its members in the following manner:

(1) Each member is to be provided basic health services for a basic health services payment which (A) is to be paid on a periodic basis without regard to the dates health services (within the basic health services) are provided; (B) is fixed without regard to the frequency, extent, or kind of health service (within the basic health services) actually furnished; (C) *except in the case of basic health services provided a member who is a full-time student as defined by the Secretary) at an accredited institution of higher education,* is fixed under a community rating system; and (D) may be supplemented by additional nominal payments which may be required for the provision of specific services (within the basic health services), except that such payments may not be required where or in such a manner that they serve (as determined under regulations of the Secretary) as a barrier to the delivery of health services. Such additional nominal payments shall be fixed in accordance with the regulations of the Secretary. A health maintenance organization may include a health service, defined as a supplemental health service by section 1302(2), in the basic health services provided its members for a basic health services payment described in the first sentence. In the case of an entity which before it became a qualified health maintenance organization (within the meaning of section 1310(d) provided comprehensive health services on a prepaid basis, the requirement of clause (C) shall not apply to such entity until the expiration of the forty-eight month period beginning with the month following the month in which the entity became such a qualified health organization. *The re-*

quirements of this paragraph respecting the basic health services payment shall not apply to the provision of basic health services to a member for an illness or injury for which the member is entitled to benefits under a workmen's compensation law or an insurance policy but only to the extent such benefits apply to such services. For the provision of such services for an illness or injury for which a member is entitled to benefits under such a law, the health maintenance organization may, if authorized by such law, charge or authorize the provider of such services to charge, in accordance with the charges allowed under such law, the insurance carrier, employer, or other entity which under such law is to pay for the provision of such services or, to the extent that such member has been paid under such law for such services, such member. For the provision of such services for an illness or injury for which a member is entitled to benefits under an insurance policy, a health maintenance organization may charge or authorize the provider of such services to charge the insurance carrier under such policy or to the extent that such member has been paid under such policy for such services, such member.

(2) For such payment or payments (hereinafter in this title referred to as "supplemental health services payments") as the health maintenance organization may require in addition to the basic health services payment, the organization may provide to each of its members any of the health services which are included in supplemental health services (as defined in section 1302(2)). Supplemental health services payments which are fixed under a community rating system *unless the supplemental health services payment is for a supplemental health service provided a member who is a full-time student (as defined by the Secretary) at an accredited institution of higher education*, except that, in the case of an entity which before it became a qualified health maintenance organization (within the meaning of section 1310(d)) provided comprehensive health services on a prepaid basis, the requirement of this sentence shall not apply to such entity during the forty-eight month period beginning with the month following the month in which the entity became such a qualified health maintenance organization.

(3) The services of health professionals which are provided as basic health services shall be provided through health professionals who are members of the staff on the health maintenance organization, through a medical group (or groups), through an or individual practice association (or associations), through health professionals who have contracted with the health maintenance organization for the provision of such services, or through any combination of such staff, medical group (or groups), individual practice association (or associations), or health professionals under contract with the organization, except that this paragraph shall not apply in the case [(A)] health professionals' services which the organization determines, in conformity with regulations of the Secretary, are unusual or infrequently used, or [(B)] any basic health service provided a member of the health maintenance organization other than by such a health professional because it

was medically necessary that the service be provided to the member before he could have it provided by such a health professional. A health maintenance organization may also, during the [thirty-six] *forty-eight* month period beginning with the month following the month in which the organization becomes a qualified health maintenance organization (within the meaning of section 1310 (d)), provide basic and supplemental health services through an entity which but for the requirement of section 1302(4)(C)(i) would be a medical group for purposes of this title. After the expiration of such period, the organization may provide basic or supplemental health services through such an entity only if authorized by the Secretary in accordance with the regulations which take into consideration the unusual circumstances of such entity. [A health maintenance organization may not, in any of its fiscal years, enter into contracts with health professionals or entities other then medical groups or individual practice associations if the amounts paid under such contracts for basic and supplemental health services exceed fifteen percent of the total amount to be paid in such fiscal year by the health maintenance organization to physicians for the provision of basic and supplemental health services, or, if the health maintenance organization principally serves a rural area, thirty percent of such amount, except that this sentence does not apply to the entering into of contracts for the purchase of basic and supplemental health services through an entity which but for the requirements of section 1302(4)(C)(i) would be a medical group for purposes of this title.] *A health maintenance organization may not enter into contracts with physicians (other than physicians who are members of the staff of the organization) or with entities other than medical groups or individual practice associations for the services of physicians if the amounts to be paid under such contracts for the provision of basic and supplemental health services—*

(A) in the first four fiscal years of the organization beginning after the month in which the organization becomes a qualified health maintenance organization (within the meaning of section 1310(d)) exceed 50 per centum of the total amount to be paid by the organization in such fiscal year for the provision of basic and supplemental health services by physicians, and

(B) in the fifth and succeeding fiscal years of the organization beginning after such month exceed (i) 15 per centum of the total amount to be paid by the organization in such fiscal year for the provision of such services by physicians, or (ii) in the case of a health maintenance organization which principally serves a rural area, 30 per centum of such total amount.

The limitations prescribed by the preceeding sentence do not apply to contracts for the provision of basic and supplemental health services through an entity which but for the requirements of section 1302 (4)(C)(i) would be a medical group for purposes of this title. Contracts between a health maintenance organization and health professionals for the provision of basic and supplemental health services shall include such provisions as the Secretary may require (including provisions requiring appropriate continuing education). For pur-

poses of this paragraph, the term "health professionals" means physicians, dentists, nurses, podiatrists, optometrists, and such other individuals engaged in the delivery of health services as the Secretary may by regulation designate.

(4) Basic health services (and only such supplemental health services as members have contracted for) shall within the area served by the health maintenance organization be available and accessible to each of its members promptly as appropriate and in a manner which assures continuity, and when medically necessary be available and accessible twenty-four hours a day and seven days a week. A member of a health maintenance organization shall be reimbursed by the organization for his expenses in securing basic or supplemental health services other than through the organization if it was medically necessary that the services be provided before he could secure them through the organization *except that a member shall not be reimbursed for any service provided other than through the organization because the member intentionally left the area served by the organization for the purpose of securing such service.*

(5) To the extent that a major disaster, war, riot, civil insurrection, or any other event not reasonably within the control of a health maintenance organization (as determined under regulations of the Secretary) results in the facilities, personnel, or financial resources of a health maintenance organization not being available to provide or arrange for the provision of a basic or supplemental health service in accordance with the requirements of paragraph (1) through (4) of this subsection, such requirements only require the organization to make a good-faith effort to provide or arrange for the provision of such service within such limitation on its facilities, personnel, or resources.

(c) Each health maintenance organization shall—

(1) (*A*) have a fiscally sound operation and adequate provision against the risk of insolvency which is satisfactory to the Secretary, *and* (*B*) *have administrative and managerial arrangements and capabilities satisfactory to the Secretary*;

(2) assume full financial risk on a prospective basis for the provision of basic health services, except that a health maintenance organization may obtain insurance or make other arrangements (A) for the cost of providing to any member basic health services the aggregate value of which exceeds $5,000 in any year, (B) for the cost of basic health services provided to its members other than through the organization because medical necessity required their provision before they could be secured through the organization, and (C) for not more than 90 per centum of the amount by which its costs for any of its fiscal years exceed 115 per centum of its income for such fiscal year;

(3) (*A*) enroll persons who are broadly representative of the various age, social, and income groups within the area it serves, except that in the case of a health maintenance organization which has a medically underserved population located (in whole or in part) in the area it serves, not more than 75 per centum of the members of that organization may be enrolled from the

medically underserved population unless the area in which such population resides is also a rural area (as designated by the Secretary), *and (B) carry out enrollment of members who are entitled to medical assistance under a State plan approved under title XIX of the Social Security Act in accordance with procedures approved under regulations promulgated by the Secretary*;

(4) have an open enrollment period in accordance with the provisions of subsection (d);

(5) not expel or refuse to re-enroll any member because of his health status or his requirements for health services;

(6) *(6)(A) in the case of a private health maintenance organization,* be organized in such a manner that assures that [(A)] *(i)* at least one-third of the membership of the policymaking body of the health maintenance organization will be members of the organization, and [(B)](ii) there will be equitable representation on such body of members from medically underserved populations served by the organization, *and (B) in the case of a public health maintenance organization, have an advisory board to the policymaking body of the public entity which operates the organization which board meets the requirements of clause (A) of this paragraph and to which may be delegated policymaking authority for the organization*;

(7) be organized in such a manner that provides meaningful procedures for hearing and resolving grievances between the health maintenance organization (including the medical group or groups and other health delivery entities providing health services for the organization) and the members of the organization;

(8) have organizational arrangements, established in accordance with regulations of the Secretary, for an ongoing quality assurance program for its health services which program (A) stresses health outcomes, and (B) provides review by physicians and other health professionals of the process followed in the provision of health services;

(9) provide medical social services for its members and encourage and actively provide for its members health education services, education in the appropriate use of health services, and education in the contribution each member can make to the maintenance of his own health;

(10) provide, or make arrangements for, continuing education for its health professional staff; and

(11) provide, in accordance with regulations of the Secretary (including safeguards concerning the confidentiality of the doctor-patient relationship), an effective procedure for developing, compiling, evaluating, and reporting to the Secretary, statistics and other information (which the Secretary shall publish and disseminate on an annual basis and which the health maintenance organization shall disclose, in a manner acceptable to the Secretary, to its members and the general public) relating to (A) the cost of its operations, (B) the patterns of utilization of its services, (C) the availability, accessibility, and acceptability of its services, (D) to the extent practicable, developments

in the health status of its members, and (E) such other matters as the Secretary may require.

(d) (1) (A) A health maintenance organization which—

(i) has for at least 5 years provided comprehensive health services on a prepaid basis, or

(ii) has an enrollment of at least 50,000 members,

shall have at least once during each fiscal year next following a fiscal year in which it did not have a financial deficit an open enrollment period (determined under subparagraph (B)) during which it shall accept individuals for membership in the order in which they apply for enrollment and, except as provided in paragraph (2), without regard to preexisting illness, medical condition, or degree of disability.

(B) An open enrollment period for a health maintenance organization shall be the lesser of—

(i) 30 days, or

(ii) the number of days in which the organization enrolls a number of individuals at least equal to 3 percent of its total net increase in enrollment (if any) in the fiscal year preceding the fiscal year in which such period is held.

For the purpose of determining the total net increase in enrollment in a health maintenance organization, there shall not be included any individual who is enrolled in the organization through a group which had a contract for health care services with the health maintenance organization at the time that such health maintenance organization was determined to be a qualified health maintenance organization under section 1310.

(2) Notwithstanding the requirements of paragraph (1) a health maintenance organization shall not be required to enroll individuals who are confined to an institution because of chronic illness, permanent injury, or other infirmity which would cause economic impairment to the health maintenance organization if such individual were enrolled.

(3) A health maintenance organization may not be required to make the effective date of benefits for individuals enrolled under this subsection less than 90 days after the date of enrollment.

(4) The Secretary may waive the requirements of this subsection for a health maintenance organization which demonstrates that compliance with the provisions of this subsection would jeopardize its economic viability in its service area.

DEFINITIONS

SEC. 1302. For purposes of this title:

(1) The term "basic health services" means—

(A) physician services (including consultant and referral services by a physician);

(B) inpatient and outpatient hospital services;

(C) medically necessary emergency health services;

(D) short-term (not to exceed twenty visits), outpatient evaluative and crisis intervention mental health services;

(E) medical treatment and referral services (including referral services to appropriate ancillary services) for the abus of or addiction to alcohol and drugs;

(F) diagnostic laboratory and diagnostic and therapeutic radiologic services;

(G) home health services; and

(H) preventive health services (including (i) immunizations, (ii) well-child care from birth, (iii) periodic health evaluations for adults, (iv) voluntary family planning services, (v) infertility services, and (vi) children's eye and ear examinations conducted to determine the need for vision and hearing correction).

[*Such term does not include a health service which the Secretary, upon application of a health maintenance organization, determines is unusual and infrequently provided and not necessary for the protection of individual health. The Secretary shall publish in the Federal Register each determination made my him under the preceding sentence.*

If a service of a physician described in the preceeding sentence may also be provided under applicable State law by a dentist, optometrist, podiatrist, or other health care personnel a heatlh maintenance organization may provide such service through a dentist, optometrist, podiatrist, or other health care personnel (as the case may be) licensed to provide such service. For purposes of this paragraph, the term "home health services" means health services provided at a member's home by health care personnel, as prescribed or directed by the responsible physician or other authority designated by the health maintenance organization. A health maintenance organization is authorized, in connection with the prescription of drugs, to maintain, review, and evaluate (in accordance with regulations of the Secretary) a drug use profile of its members receiving such service, evaluate patterns of drug utilization to assure optimum drug therapy, and provide for instruction of its members and of health professionals in the use of prescription and non-prescription drugs.

(2) The term "supplemental health services" means—

(A) services of facilities for intermediate and long-term care;

(B) vision care not included as a basic health service;

(C) dental services not included as a basic health service;

(D) mental health services not included as a basic health service under paragraph (1)(D);

(E) long-term physical medicine and rehabilitative services (including physical therapy);

(F) the provision of prescription drugs prescribed in the course of the provision by the health maintenance organization of a basic health service or a service described in the preceding subparagraphs of this paragraph; and

(G) other health services which are not included as basic health services and which have been approved by the Secretary for delivery as supplemental health services.

If a service of a physician described in the preceding sentence may also be provided under applicable State law by a dentist, optometrist, podiatrist, or other health care personnel, a health maintenance organization may provide such service through an optometrist, dentist, podiatrist, or other health care personnel (as the case may be) licensed to provide such service. A health maintenance organization is authorized, in connection with the prescription or provision of prescription drugs, to maintain, review, and evaluate (in accordance with

regulations of the Secretary) a drug use profile of its members receiving such services, evaluate patterns of drug utilization to assure optimum drug therapy, and provide for instruction of its members and of health professionals in the use of prescription and non-prescription drugs.

(3) The term "member" when used in connection with a health maintenance organization means an individual who has entered into a contractual agreement, or on whose behalf a contractual arrangement has been entered into, with the organization under which the organization assumes the responsibility for the provision to such individual of basic health services and of such supplemental health services as may be contracted for.

(4) The term "medical group" means a partnership, association, or other group—

(A) which is composed of health professionals licensed to practice medicine or osteopathy and of such other licensed health professionals (including dentists, optometrists, and podiatrists) as are necessary for the provision of health services for which the group is responsible;

(B) a majority of the members of which are licensed to practice medicine or osteopathy; and

(C) the members of which (i) as their principal professional activity engage in the coordinated practice of their profession and as a group responsibility have substantial responsibility for the delivery of health services to members of a health maintenance organization; (ii) pool their income from practice as members of the group and distribute it among themselves according to a prearranged salary or drawing account or other similar plan unrelated to the provision of specific health services; (iii) share medical and other records and substantial portions of major equipment and of professional, technical, and administrative staff; (iv) arrange for and encourage continuing education in the field of clinical medicine and related areas for the members of the group; and (v) establish an arrangement whereby a member's enrollment status is not known to the health professional who provides health services to the member.

(5) The term "individual practice association" means a partnership, corporation, association, or other legal entity which has entered into a services arrangement (or arrangements) with persons who are licensed to practice medicine, osteopathy, dentistry, podiatry, optometry, or other health profession in a State and a majority of whom are licensed to practice medicine or osteopathy. Such an arrangement shall provide—

(A) that such persons shall provide their professional services in accordance with a compensation arrangement established by the entity; and

(B) to the extent feasible (i) for the sharing by such persons of medical and other records, equipment, and professional, technical, and administrative staff, and (ii) for the arrangement and encouragement of the continuing education of such persons in the field of clinical medicine and related areas.

(6) The term "health systems agency" means an entity which is designated in accordance with section 1515 of this Act.

(7) The term "medically underserved population" means the population of an urban or rural area designated by the Secretary as an area with a shortage of personal health services or a population group designated by the Secretary as having a shortage of such services. Such a designation may be made by the Secretary only after consideration of the comments (if any) of (A) each State health planning and development agency which covers (in whole or in part) such urban or rural area or the area in which such population group resides, and (B) each health systems agency designated for a health service area which covers (in whole or in part) such urban or rural area or the area in which such population group resides.

(8) The term "community rating system" means a system of fixing rates of payments for health services. Under such a system rates of payments may be determined on a per-person or per-family basis and may vary with the number of persons in a family, but except as otherwise authorized in the next sentence, such rates must be equivalent for all individuals and for all families of similar composition. The following differentials in rates of payments may be established under such system:

(A) Nominal differentials in such rates may be established to reflect differences in marketing costs and the different administrative costs of collecting payments from the following categories of members:

(i) Individual members (including their families).

(ii) Small groups of members (as determined under regulations of the Secretary).

(iii) Large groups of members (as determined under regulations of the Secretary).

(B) Nominal differentials in such rates may be established to reflect the composition of the rates of payment in a systematic manner to accommodate group purchasing practices of the various employers.

(C) Differentials in such rates may be established for members enrolled in a health maintenance organization pursuant to a contract with a governmental authority under section 1079 or 1086 of title 10, United States Code, or under any other governmental program (other than the health benefits program authorized by chapter 89 of title 5, United States Code) or any health benefits program for employees of States, political subdivision of States, and other public entities.

(9) The term "non-metropolitan area" means an area no part of which is within an area designated as a standard metropolitan statistical area by the Office of Management and Budget and which does not contain a city whose population exceeds fifty thousand individuals.

GRANTS, CONTRACTS, AND LOAN GUARANTEES FOR PLANNING AND FOR INITIAL DEVELOPMENT COSTS

SEC. 1304. (a) The Secretary may—

(1) make grants to and enter into contracts with public or nonprofit private entities for planning projects for the establishment of health maintenance organizations or for the significant expan-

sion of the membership of, or areas served by, health maintenance organizations; and

(2) guarantee to non-Federal lenders payment of the principal of and the interest on loans made to—

(A) nonprofit private entities for planning projects for the establishment or expansion of health maintenance organizations, or

(B) other private entities for such projects for health maintenance organizations which will serve medically underserved populations.

Planning projects assisted under this subsection shall include development of plans for the marketing of the services of the health maintenance organization.

(b) (1) The Secretary may—

(A) make grants to and enter into contracts with public or nonprofit private entities for projects for the initial development of health maintenance organizations; and

(B) guarantee to non-Federal lenders payment of the principal of and the interest on loans made to—

(i) nonprofit private entities for projects for the initial development of health maintenance organizations, or

(ii) other private entities for such projects for health maintenance organizations which will serve medically underserved populations.

(2) For purposes of this section, the term "initial development" when used to describe a project for which assistance is authorized by this subsection [includes] *means the establishment of a health maintenance organization or the* significant expansion of the membership of, or the area served by, a health maintenance organization. Funds under grants and contracts under this subsection and under loans guaranteed under this subsection may only be utilized for such purposes as the Secretary may prescribe in regulations. Such purposes may include (A) the implementation of an enrollment campaign for such an organization. (B) the detailed design of and arrangements for the health services to be provided by such an organization, (C) the development of administrative and internal organizational arrangements, including fiscal control and fund accounting procedures, and the development of a capital financing program. (D) the recruitment of personnel who will engage in practice principally for the health maintenance organization and the conduct of training activities for such personnel, and (E) the payment of architects' and engineers' fees.

(3) A grant or contract under this subsection may only be made or entered into for initial development costs [in the one-year period beginning on] *incurred in a period not to exceed three years from* the first day of the first month in which such grant or contract is made or entered into. [The number of grants made for any initial development project under this subsection when added to the number of contracts entered into for such project under this subsection may not exceed three.] A loan guarantee under this subsection may only be made for a loan (or loans) for such costs incurred in a period not to exceed three years.

(c) (1) An application for a grant, contract, or loan guarantee under subsection (a) for a planning project shall contain assurances satis-

factory to the Secretary that in carrying out the planning project for which the grant, contract, or loan guarantee is sought, the applicant will (A) cooperate with each health systems agency designated for a health service area which covers (in whole or in part) the area proposed to be served by the health maintenance organization for which the planning project will be conducted, and (B) notify the medical society serving such area of the planning project.

(2) If the Secretary makes a grant or loan guarantee or enters into a contract under subsection (a) for a planning project for a health maintenance organization, he may, within the period in which the planning project must be completed, make a grant or loan guarantee or enter into a contract under subsection (b) for the initial development of that health maintenance organization; but no grant or loan guarantee may be made or contract entered into under subsection (b) for initial development of a health maintenance organization unless the Secretary determines that (A) sufficient planning for its establishment or expansion (as the case may be) has been conducted by the applicant for the grant, contract, or loan guarantee, and (B) the feasibility of establishing and operating, or of expanding, the health maintenance organization has been established by the applicant.

(d) In considering applications for grants and contracts under this section, the Secretary shall give priority to an application which contains or is supported by assurances satisfactory to the Secretary that at the time the health maintenance organization for which such application is submitted first becomes operational not less than 30 per centum of its members will be members of a medically underserved population. In considering applications for loan guarantees under this section, the Secretary shall give special consideration to applications for projects for health maintenance organizations which will serve medically underserved populations.

(e)(1) Except as provided in paragraph (2), the following limitations apply with respect to grants, loan guarantees, and contracts made under subsection (a) of this section:

(A) If a planning project has been assisted with grant, loan guarantee, or contract under subsection (a), the Secretary may not make any other planning grant or loan guarantee or enter into any other planning contract for such project under this section.

(B) Any project for which a grant or loan guarantee is made or contract entered into must be completed within twelve months from the date the grant or loan guarantee is made or contract entered into.

(2) The Secretary may not make more than one additional grant or loan guarantee or enter into not more than one additional contract for a planning project for which a grant or loan guarantee has previously been made or a contract previously entered into, and he may permit additional time (up to twelve months) for completion of the project if he determines that the additional grant, loan guarantee, or contract (as the case may be), or additional time, or both, is needed to adequately complete the project.

(f)(1) The amount to be paid by the United States under a grant made, or contract entered into, under subsection (a) for a planning project, and (except as provided in paragraph (3) of this subsection)

the amount of principal of a loan for a planning project which may be guaranteed under such subsection, shall be determined by the Secretary, except that (A) the amount to be paid by the United States under any single grant or contract, and the amount of principal of any single loan guaranteed under such subsection, may not exceed $200,000, and (B) the aggregate of the amounts to be paid for any project by the United States under grants or contracts, or both, under such subsection, and the aggregate amount of principal of loans guaranteed under such subsection for any project, may not exceed the greater of (i) 90 per centum of the cost of such project (as determined under regulations of the Secretary), or (ii) in the case of a project for a health maintenance organization which will serve a medically underserved population, such greater percentage (up to 100 per centum) of such cost as the Secretary may prescribe if he determines that the ceiling on the grants, contracts, and loan guarantees (or any combination thereof) for such project should be determined by such greater percentage.

(2) The amount to be paid by the United States under a grant made, or contract entered into, under subsection (b) for an initial development project, and (except as provided in paragraph (3) of this subsection) the amount of principal of a loan for an initial development project which may be guaranteed under such subsection, shall be determined by the Secretary; except that the amounts to be paid by the United States for any initial development project under grants or contracts, or both, under such subsection, and the aggregate amount of principal of loans guaranteed under such subsection for any project, may not exceed the lesser of—

[(A) $1,000,000, or, in the case of a project for a health maintenance organization which will provide services to an additional service area (as defined by the Secretary) or which will provide services in one or more areas which are not contiguous, $1,600,000, or]

(A) $1,000,000 in the case of a project for the establishment of a health maintenance organization or $600,000 in the case of a project for the significant expansion of the membership of or areas served by a health maintenance organization, or

(B) an amount equal to the greater of (i) 90 per centum of the cost of such project (as determined under regulations of the Secretary), or (ii) in the case of a project for a health maintenance organization which will serve a medically underserved population, such greater percentage (up to 100 per centum) of such cost as the Secretary may prescribe if he determines that the ceiling on the grants, contracts, and loan guarantees (or any combination thereof) for such project should be determined by such greater percentage.

(3) The cumulative total of the principal of the loans outstanding at any time with respect to which guarantees have been issued under this section may not exceed such limitations as may be specified in appropriation Acts.

(g) Payments under grants under this section may be made in advance or by way of reimbursement and at such intervals and on such conditions as the Secretary finds necessary.

(h) Contracts may be entered into under this section without regard to sections 3648 and 3709 of the Revised Statutes (31 U.S.C. 529; 41 U.S.C. 5).

(i) Payments under grants and contracts under this section shall be made from appropriations under section 1309(a).

(j) Loan guarantees under subsection (a)(2) for planning projects [may be made through September 30, 1978;] and loan guarantees under subsection (b)(1)(B) for initial development projects may be made through the fiscal year ending September 30, [1979] *1981.*

(k)(1) Of the sums appropriated for any fiscal year under section 1309(a) for grants and contracts under subsection (a) of this section, not less than 20 per centum shall be set aside and obligated in such fiscal year for projects (A) to plan the establishment or expansion of health maintenance organizations which the Secretary determines may reasonably be expected to have after their establishment or expansion not less than 66 per centum of their membership drawn from residents of non-metropolitan areas, and (B) the applications for which meet the requirements of this title for approval. Sums set aside in any fiscal year for projects described in the preceding sentence but not obligated in such fiscal year for grants and contracts under subsection (a) of this section because of a lack of applicants for projects meeting the requirements of such sentence shall remain available for obligation under such subsection in the succeeding fiscal year for any project, with priority being given to projects described in clause (A) of such sentence.

(2) Of the sums appropriated for any fiscal year under section 1309(a) for grants and contracts under subsection (b) of this section, not less than 20 per centum shall be set aside and obligated in such fiscal year for projects (A) for the initial development of health maintenance organizations which the Secretary determines may reasonably be expected to have after their initial development not less than 66 per centum of their membership drawn from residents of non-metropolitan areas, and (B) the applications for which meet the requirements of this title for approval. Sums set aside in any fiscal year for projects described in the preceding sentence but not obligated in such fiscal year for grants and contracts under subsection (b) of this section because of a lack of applicants for projects meeting the requirements of such sentence shall remain available for obligation under such subsection in the succeeding fiscal year for any project, with priority being given to projets described in clause (A) of such sentence.

LOANS AND LOAN GUARANTEES FOR INITIAL [OPERATION COSTS] *COSTS OF OPERATION*

SEC. 1305. (a) The Secretary may—

(1) make loans to public or nonprofit private health maintenance organizations to assist them in meeting the amount by which their [operating costs] *costs of operation* during a period not to exceed the first sixty months of their operation exceed their revenues in that period;

(2) make loans to public or nonprofit private health maintenance organizations to assist them in meeting the amount by which their [operating costs] *costs of operation*, which the Secretary

determines are attributable to significant expansion in their membership or area served and which are incurred during a period not to exceed the first sixty months of their operation after such expansion, exceed their revenues in that period which the Secretary determines are attributable to such expansion; and

(3) guarantee to non-Federal lenders payment of the principal of and the interest on loans made to—

(A) nonprofit private health maintenance organizations for the amounts referred to in paragraph (1) or (2), or

(B) other private health maintenance organizations for such amounts but only if the health maintenance organization will serve a medically underserved population.

No loan or loan guarantee may be made under this subsection for the [operating costs] *costs of operation* of a health maintenance organization unless the Secretary determines that the organization has made all reasonable attempts to meet such costs.

(b)(1) Except as provided in paragraph (2), the aggregate amount of principal of loans made or guaranteed, or both, under this section for a health maintenance organization may not exceed [$2,500,000] *$4,000,000*. In any [fiscal year] *twelve-month period* the amount disbursed to a health maintenance organization under this section (either directly by the Secretary or by an escrow agent under the terms of an escrow agreement or by a lender under a loan guaranteed under this section) may not exceed [$1,000,000] *$2,000,000*.

(2) The cumulative total of the principal of the loans outstanding at any time which have been directly made or with respect to which guarantees have been issued under subsection (a) may not exceed such limitations as may be specified in appropriation Acts.

(c) Loans under this section shall be made from the fund established under section 1308(e).

(d) No loan may be made or guaranteed under this section after September 30, [1980] *1981*.

(e) Of the sums used for loans under this section in any fiscal year from the loan fund established under section 1308(e), not less than 20 per centum shall be used for loans for projects (1) for the initial operation of health maintenance organizations which the Secretary determines have not less than 66 per centum of their membership drawn from residents of nonmetropolitan areas, and (2) the applications for which meet the requirements of this title for approval.

(f) In considering applications for loan guarantees under this section, the Secretary shall give special consideration to applications for health maintenance organizations which will serve medically underserved populations.

LOANS AND LOAN GUARANTEES FOR ACQUISITION AND CONSTRUCTION OF AMBULATORY HEALTH CARE FACILITIES

Sec. 1305A. (a) The Secretary may—

(1) make loans, from the fund established under section 1308(e), to public and nonprofit private health maintenance organizations for projects for the acquisition or construction of ambulatory health care facilities and for the acquisition of equip-

ment for facilities acquired or constructed under a loan made under this paragraph; and

(2) guarantee to—

(A) non-Federal lenders for their loans to nonprofit health maintenance organizations for projects described in paragraph (1) and to private health maintenance organizations for such projects which will serve medically undeserved populations, and

(B) the Federal Financing Bank for its loans to nonprofit private health maintenance organizations for projects described in paragraph (1) and to private health maintenance organizations for such projects which will serve medically undeserved populations,

the payment of principal and interest on such loans.

(b) (1) Except as provided in paragraph (2), the aggregate amount of principal of loans made or guaranteed, or both, under subsection (a) for a health maintenance organization may not exceed $2,500,000.

(2) The cumulative total of the principal of the loans outstanding at any time which have been directly made or with respect to which guarantees have been issued under subsection (a) may not exceed such limitations as may be specified in appropriation Acts.

(3) The authority of the Secretary to make loans under subsection (a) shall be effective for any fiscal year only to such extent or in such amounts as are provided in advance in appropriation Acts.

(c) For purposes of this section—

(1) the term "ambulatory health care facility" means a health care facility for the provision of diagnostic, treatment, and prevention services to ambulatory patients; and

(2) the term "construction" means the (A) construction of new facilities, (B) alteration, expansion, remodeling, replacement, and renovation of existing facilities, (C) cost of offsite improvements in connection with an activity described in clause (A) or (B), and (D) cost of the acquisition of land in connection with an activity described in clause (A), (B), or (C).

APPLICATION REQUIREMENTS

SEC. 1306. (a) No grant, contract, loan, or loan guarantee may be made under this title unless an application therefor has been submitted to and approved by the Secretary.

(b) The Secretary may not approve an application for a grant, contract, loan, or loan guarantee under this title unless—

(1) in the case of an application for assistance under section 1303 or 1304, such application meets the application requirements of such section and in the case of an application for a loan or loan guarantee, such application meets the requirements of section 1308;

(2) *in the case of an application for assistance under section 1304, 1305, or 1305A*, he determines that the applicant making the application would not be able to complete the project or undertaking for which the application is submitted without the assistance applied for;

(3) the application contains satisfactory specification of the existing or anticipated (A) population group or groups to be served by the proposed or existing health maintenance organization described in the application, (B) membership of such organization, (C) methods, terms, and periods of the enrollment of members of such organization, (D) estimated costs per member of the health and educational services to be provided by such organization and the nature of such costs, (E) sources of professional services for such organization, and organizational arrangements of such organization for providing health and educational services, (F) organizational arrangements of such organization for an ongoing quality assurance program in conformity with the requirements of section 1301(c), (G) sources of prepayment and other forms of payment for the services to be provided by such organization, (H) facilities, and additional capital investments and sources of financing therefor, available to such organization to provide the level and scope of services proposed, (I) administrative, managerial, and financial arrangements and capabilities of such organization, (J) role of members in the planning and policymaking for such organization, (K) grievance procedures for members of such organization, and (L) evaluations of the support for and acceptance of such organization by the population to be served, the sources of operating support, and the professional groups to be involved or affected thereby;

(4) contains or is supported by assurances satisfactory to the Secretary that the applicant making the application will, in accordance with such criteria as the Secretary shall by regulation prescribe, enroll, and maintain an enrollment of the maximum number of members that its available and potential resources (as determined under regulations of the Secretary) will enable it to effectively serve;

[(5) each health systems agency designated for a health service area which covers (in whole or in part) the area to be served by the health maintenance organization for which such application is submitted:]

(5) in the case of an application which is made for a health maintenance organization, contains or is supported by assurances satisfactory to the Secretary that the organization will comply with the requirements of paragraphs (2), (3), and (4) of section 1310(d);

(6) in the case of an application made for a project which previously received a grant, contract, loan, or loan guarantee under this title, such application contains or is supported by assurances satisfactory to the Secretary that the applicant making the application has the financial capability to adequately carry out the purposes of such project and has developed and operated such project in accordance with the requirements of this title and with the plans contained in preivious applications for such assistance;

(7) the application contains such assurances as the Secretary may require respecting the intent and the ability of the applicant to meet the requirements of paragraphs (1) and (2) of section 1301(b) respecting the fixing of basic health services payments

and supplemental health services payments under a community rating system; and

(8) the application is submitted in such form and manner, and contains such additional information, as the Secretary shall prescribe in regulations.

An organization making multiple applications for more than one grant, contract, loan, or loan guarantee under this title, simultaneously or over the course of time, shall not be required to submit duplicate or redundant information but shall be required to update the specifications (required by paragraph (3)) respecting the existing or proposed health maintenance organization in such manner and with such frequency as the Secretary may by regulation prescribe.

(c) The Secretary shall by regulation establish standards and procedures for health systems agencies to follow in reviewing and commenting on applications for grants, contracts, loans, and loan guarantees under this title.

* * * * * * *

GENERAL PROVISIONS RELATING TO LOAN GUARANTEES AND LOANS

SEC. 1308. (a)(1) The Secretary may not approve an application for a loan guarantee under this title unless he determines that (A) the terms, conditions, security (if any), and schedule and amount of repayments with respect to the loan are sufficient to protect the financial interests of the United States and are otherwise reasonable, including a determination that the rate of interest does not exceed such per centum per annum on the principal obligation outstanding as the Secretary determines to be reasonable, taking into account the range of interest rates prevailing in the private market for loans with similar maturities, terms, conditions, and security and the risks assumed by the United States, and (B) the loan would not be available on reasonable terms and conditions without the guarantee under this title.

(2)(A) The United States shall be entitled to recover from the applicant for a loan guarantee under this title the amount of any payment made pursuant to such guarantee, unless the Secretary for good cause waives such right of recovery; and, upon making any such payment, the United States shall be subrogated to all of the rights of the recipient of the payments with respect to which the guarantee was made.

(B) To the extent permitted by subparagraph (C), any terms and conditions applicable to a loan guarantee under this title (including terms and conditions imposed under subparagraph (D)) may be modified by the Secretary to the extent he determines it to be consistent with the financial interest of the United States.

(C) Any loan guarantee made by the Secretary under this title shall be incontestable (i) in the hands of an applicant on whose behalf such guarantee is made unless the applicant engaged in fraud or misrepresentation in securing such guarantee, and (ii) as to any person (or his successor in interest) who makes or contracts to make a loan to such applicant in reliance thereon unless such person (or his successor in interest) engaged in fraud or misrepresentation in making or contracting to make such loan.

(D) Guarantees of loans under this title shall be subject to such further terms and conditions as the Secretary determines to be necessary to assure that the purposes of this title will be achieved.

(b)(1) The Secretary may not approve an application for a loan under this title unless—

(A) the Secretary is reasonably satisfied that the applicant therefor will be able to make payments of principal and interest thereon when due, and

(B) the applicant provides the Secretary with reasonable assurances that there will be available to it such additional funds as may be necessary to complete the project or undertaking with respect to which such loan is requested.

(2) Any loan made under this title shall (A) have such security, (B) have such maturity date, (C) be repayable in such installments, (D) bear interest at a rate comparable to the current rate of interest prevailing, on the date the loan is made, with respect to marketable obligations of the United States of comparable maturities, adjusted to provide for appropriate administrative charges, and (E) be subject to such other terms and conditions (including provisions for recovery in case of default), as the Secretary determines to be necessary to carry out the purposes of this title while adequately protecting the financial interests of the United States.

(3) The Secretary may, for good cause but with due regard to the financial interests of the United States, waive any right of recovery which he has by reason of the failure of a borrower to make payments of principal of and interest on a loan made under this title, except that if such loan is sold and guaranteed, any such waiver shall have no effect upon the Secretary's guarantee of timely payment of principal and interest.

(c)(1) The Secretary may from time to time, but with due regard to the financial interests of the United States, sell loans made by him under this title.

(2) The Secretary may agree, prior to his sale of any such loan, to guarantee to the purchaser (and any successor in interest of the purchaser) compliance by the borrower with the terms and conditions of such loan. Any such agreement shall contain such terms and conditions as the Secretary considers necessary to protect the financial interests of the United States or as otherwise appropriate. Any such agreement may (A) provide that the Secretary shall act as agent of any such purchaser for the purpose of collecting from the borrower to which such loan was made and paying over to such purchaser, any payments of principal and interest payable to such organization under such loan; and (B) provide for the repurchase by the Secretary of any such loan on such terms and conditions as may be specified in the agreement. The full faith and credit of the United States is pledged to the payment of all amounts which may be required to be paid under any guarantee under this paragraph.

(3) After any loan under this title to a public health maintenance organization has been sold and guaranteed under this subsection, interest paid on such loan which is received by the purchaser thereof (or his successor in interest) shall be included in the gross income of the purchaser of the loan (or his successor in interest) for the purpose of chapter 1 of the Internal Revenue Code of 1954.

(4) Amounts received by the Secretary as proceeds from the sale of loans under this subsection shall be deposited in the loan fund established under subsection (e).

(5) Any reference in this title (other than in this subsection and in subsection (d)) to a loan guarantee under this title does not include a loan guarantee made under this subsection.

(d)(1) There is established in the Treasury a loan guarantee fund (hereinafter in this subsection referred to as the "fund") which shall be available to the Secretary without fiscal year limitation, in such amounts as may be specified from time to time in appropriation Acts, to enable him to discharge his responsibilities under loan guarantees issued by him under this title *and to take the action authorized by subsection (f)*. There are authorized to be appropriated from time to time such amounts as may be necessary to provide the sums required for the fund. To the extent authorized in appropriation Acts, there shall also be deposited in the fund amounts received by the Secretary in connection with loan guarantees under this title and other property or assets derived by him from his operations respecting such loan guarantees, including any money derived from the sale of assets.

(2) If at any time the sums in the funds are insufficient to enable the Secretary to discharge his responsibilities under guarantees issued by him under this title: *and to take the action authorized by subsection (f)*, he is authorized to issue to the Secretary of the Treasury notes or other obligations in such forms and denominations, bearing such maturities, and subject to such terms and conditions, as may be prescribed by the Secretary with the approval of the Secretary of the Treasury. Such notes or other obligations shall bear interest at a rate determined by the Secretary of the Treasury, taking into consideration the current average market yield on outstanding marketable obligations of the United States of comparable maturities during the month preceding the issuance of the notes or other obligations. The Secretary of the Treasury shall purchase any notes and other obligations issued under this paragraph and for that purpose he may use as a public debt transaction the proceeds from the sale of any securities issued under the Second Liberty Bond Act, and the purposes for which the securities may be issued under that Act are extended to include any purchase of such notes and obligations. The Secretary of the Treasury may at any time sell any of the notes or other obligations acquired by him under this paragraph. All redemptions, purchases, and sales by the Secretary of the Treasury of such notes or other obligations shall be treated as public debt transactions of the United States. Sums borrowed under this paragraph shall be deposited in the fund and redemption of such notes and obligations shall be made by the Secretary from the fund.

(e) There is established in the Treasury a loan fund (hereinafter in this subsection referred to as the "fund") which shall be available to the Secretary without fiscal year limitation, in such amounts as may be specified from time to time in appropriation Acts, to enable him to make loans under this title *and to take the action authorized by subsection (f)*. There shall also be deposited in the fund amounts received by the Secretary as interest payments and repayment of principal on loans made under this title and other property or assets derived by him

from his operations respecting such loans, from the sale of loans under subsection (c) of this section, or from the sale of assets.

(*f*) *The Secretary may take such action as he deems appropriate to protect the interest of the United States in the event of a default on a loan made or guaranteed under this title, including taking possession of, holding, and using real property pledged as security for such a loan or loan guarantee.*

AUTHORIZATIONS OF APPROPRIATIONS

SEC. 1309. (a) For the purpose of making payments under grants and contracts under sections 1303, 1304(a), [and 1304(b)] *1304(b), and 1317* there are authorized to be appropriated $25,000,000 for the fiscal year ending June 30, 1974, $55,000,000 for the fiscal year ending June 30, 1975, $40,000,000 for the fiscal year ending June 30, 1976, $45,000,000 for the fiscal year ending September 30, 1977, [and] $45,000,000 for the fiscal year ending September 30, 1978[; and for the purpose of making payments under grants and contracts under section 1304(b) for the fiscal year ending September 30, 1979, there is authorized to be appropriated $50,000,000], *$63,000,000 for the fiscal year ending September 30, 1980, and $63,000,000 for the fiscal year ending September 30, 1981.*

(b) There is authorized to be appropriated to the loan fund established under section 1308(e) $75,000,000 in the aggregate for the fiscal years ending June 30, 1974, and June 30, 1975.

EMPLOYEES' HEALTH BENEFITS PLANS

SEC. 1310. (a)(1) In accordance with regulations which the Secretary shall prescribe—

(A) each employer—

(i) which is now or hereafter required during any calendar quarter to pay its employees the minimum wage prescribed by section 6 of the Fair Labor Standards Act of 1938 (or would be required to pay its employees such wage but for section 13(a) of such Act), and

(ii) which during such calendar quarter employed an average number of employees of not less than 25,

shall include in any health benefits plan, and

(B) any State and each political subdivision thereof which during any calendar quarter employed an average number of employees of not less than 25, as a condition of payment to the State of funds under section 314(d), 317, 318, 1002, 1525, or 1613, shall include in any health benefits plan,

offered to such employees in the calendar year beginning after such calendar quarter the option of membership in qualified health maintenance organizations which are engaged in the provision of basic health services in health maintenance organization service areas in which at least 25 of such employees reside.

(2) If any of the employees of an employer or State or political subdivision thereof described in paragraph (1) are represented by a collective bargaining representative or other employee representative designated or selected under any law, offer of membership in a quali-

fied health maintenance organization required by paragraph (1) to be made in a health benefits plan offered to such employees (A) shall first be made to such collective bargaining representative or other employee representative, and (B) if such offer is accepted by such representative, shall then be made to each such employee.

(b) If there is more than one qualified health maintenance organization which is engaged in the provision of basic and supplemental health services in the area in which the employees of an employer subject to subsection (a) reside and if—

(1) one or more of such organizations provides basic health services (A) without the use of an individual practice association and (B) without the use of contracts (except for contracts for unusual or infrequently used services) with health professionals, and

(2) one or more of such organizations provides basic health services through (A) an individual practice association (or associations), (B) health professionals who have contracted with the health maintenance organization for the provision of such services, or (C) a combination of such association (or associations) or health professionals under contract with the organization,

then of the qualified health maintenance organizations included in a health benefits plan of such employer pursuant to subsection (a) at least one shall be an organization which provides basic health services as described in clause (1) and at least one shall be an organization which provides basic health services as described in clause (2). *The Secretary, as a condition to approving as a qualified health maintenance organization for an area for purposes of this section an entity which is described in subsection (d)(1)(C) and which provides basic and supplemental health services in a manner described in paragraph (1) or (2) of this subsection, may require the health benefits plan of each employer subject to subsection (a) which has at least 25 employees residing in such area to include in such plan at least two qualified health maintenance organizations which provide such services in such area in such manner when at least two such organizations are willing to be included in such plan.*

(c) No employer shall be required to pay more for health benefits as a result of the application of this section than would otherwise be required by any prevailing collective bargaining agreement or other legally enforceable contract for the provision of health benefits between the employer and its employees. *Each employer which provides payroll deductions as a means of paying employees' contributions for health benefits or which provide a health benefits plan to which an employee contribution is not required and which is required by subsection (a) to offer his employees the option of membership in a qualified health maintenance organization shall, upon request of an employee who exercises such option, arrange for the employee's contribution for such membership to be paid through payroll deductions.*

(d)(1) For purposes of this section, the term "qualified health maintenance organization" means [(1)] (*A*) a health maintenance organization which has provided assurances satisfactory to the Secretary that it provides basic and supplemental health services to its

members in the manner prescribed by section 1301(b) and that it is organized and operated in the manner prescribed by section 1301(c) *and will meet the requirements of paragraph (2), (3), and (4) of this subsection,* [and (2)] an entity which proposes to become a health maintenance organization and which the Secretary determines will when it becomes operational provide basic and supplemental health services to its members in the manner prescribed by section 1301(b) and will be organized and operated in the manner prescribed by section 1301(c) *and will meet the requirements of paragraphs (2), (3), and (4) of this subsection, and (C) and entity described in paragraph (6)(B) of this subsection which has (i) received a waiver under such paragraph from the requirements of paragraph (6) of section 1301(c), and (ii) has provided assurances satisfactory to the Secretary that it provides basic and supplemental health services to its members in the manner prescribed by section 1301(b), that it is operated in the manner prescribed by section 1301(c), that, except with respect to the requirements of paragraph (6) of section 1301(c), it is organized in the manner prescribed by section 1301(c), and that it will meet the requirements of paragraphs (2), (3), (4) of this subsection.*

(2) Each health maintenance organization shall, in accordance with regulations promulgated by the Secretary—

(A) provide the information required to be reported under section 1124 of the Social Security Act by disclosing entities, and

(B) supply the information required to be supplied under section 1902(a)(38) of such Act.

(3)(A) Each health maintenance organization shall file with the Secretary, at such times as the Secretary shall prescribe, such information as the Secretary may require—

(i) to demonstrate that the health maintenance organization has a fiscally sound operation, and

(ii) respecting—

(I) any sale, exchange, or leasing of any property between the organization and a party in interest,

(II) any furnishing by the organization of services to a party in interest and any furnishing of services to the organization by a party in interest, and

(III) any lending of money or other extension of credit between the organization and a party in interest.

(B) Each health maintenance organization shall provide the Secretary with assurances satisfactory to the Secretary that the terms of each transaction between the health maintenance organization and a party in interest will be at least as favorable to the health maintenance organization as if the transaction was between the health maintenance organization and a person who is not a party in interest.

(C) For purposes of subparagraphs (A) and (B), the term "party in interest" means with respect to a health maintenance organization providing information under such subparagraph—

(i) a person with an ownership or control interest (as defined in section 1124(a)(3) of the Social Security Act) in the health maintenance organization,

(ii) a managing employee (as defined n section 1126(b) of such Act) of the organization,

(iii) any entity with respect to which an individual described in clause (i) or (ii) is a person with an ownership or control interest (as so defined) or a managing employee (as so defined), and

(iv) any member of the immediate family of an individual who is a person described in clause (i) or (ii).

(4) Each health maintenance organization shall make available to its members the information reported by the organization pursuant to paragraphs (2) and (3).

(5) The Secretary shall include in the annual report required by section 1315 a summary of evaluations made by the Secretary of information provided under paragraphs (2) and (3) and a description of any action taken as a result of such evaluations.

(6)(A) For purposes of paragraph (1) of this subsection, the Secretary may, upon application, grant a waiver to an entity described in subparagraph (B) from the requirements of section 1301(c)(6) upon such terms and conditions as the Secretary may determine are appropriate if the entity (i) provided, before the expiration of one hundred and eighty days after the date of the enactment of this paragraph, notice to the Secretary of its intent to apply to be a qualified health maintenance organization, and (ii) made such an application before the expiration of eighteen months after such date of enactment. No grant, contract, loan, or loan guarantee may be made under this title for an entity granted a waiver under this subparagraph.

(B) An entity eligible to apply for a waiver under subparagraph (A) is a health maintenance organization (as defined in regulations promulgated under section 1122 of the Social Security Act as in effect on the day before the date of enactment of this paragraph) (i) which is operated (but not as a separate legal entity) either by a commercial insurance carrier or a nonprofit carrier which provides hospital service benefits or medical or surgical benefits, or both, (ii) with respect to which Federal financial assistance has not been provided under this Act, and (iii) which on July 1, 1978, was engaged in providing basic health care services (as defined in regulations promulgated under such section 1122 as so in effect) to the organization's members.

(e)(1) Any employer who knowingly does not comply with one or more of the requirements of subsection (a) shall be subject to a civil penalty of not more than $10,000. If such noncompliance continues, a civil penalty may be assessed and collected under this subsection for each thirty-day period such noncompliance continues. Such penalty may be assessed by the Secretary and collected in a civil action brought by the United States in a United States district court.

(2) In any proceeding by the Secretary to assess a civil penalty under this subsection, no penalty shall be assessed until the employer charged shall have been given notice and an opportunity to present its views on such charge. In determining the amount of the penalty, or the amount agreed upon in compromise, the Secretary shall consider the gravity of the noncompliance and the demonstrated good faith of the employer charged in attempting to achieve rapid compliance after notification by the Secretary of a noncompliance.

(3) In any civil action brought to review the assessment of a civil penalty assessed under this subsection, the court shall, at the request

of any party to such action, hold a trial de novo on the assessment of such civil penalty and in any civil action to collect such a civil penalty, the court shall, at the request of any party to such action, hold a trial de novo on the assessment of such civil penalty unless in a prior civil action to review the assessment of such penalty the court held a trial de novo on such assessment.

(f) For purposes of this section, the term "employer" does not include (1) the Government of the United States, the government of the District of Columbia or any territory or possession of the United States, a State or any political subdivision there, or any agency or instrumentality (including the United States Postal Service and Postal Rate Commission) of any of the foregoing; or (2) a church, convention or association of churches, or any organization operated, supervised or controlled by a church, convention or association of churches which organization (A) is an organization described in section 501(c)(3) of the Internal Revenue Code of 1954, and (B) does not discriminate (i) in the employment, compensation, promotion, or termination of employment of any personnel, or (ii) in the extension of staff or other privileges to any physician or other health personnel, because such persons seek to obtain or obtained health care, or participate in providing health care, through a health maintenance organization.

(g) If the Secretary, after reasonable notice and opportunity for hearing to a State, finds that it or any of its political subdivisions has failed to comply with one or more of the requirements of subsection (a), the Secretary shall terminate payments to such State under sections 314(d), 317, 318, 1002, 1525, and 1613 and notify the Governor of such State that further payments under such sections will not be made to the State until the Secretary is satisfied that there will no longer be any such failure to comply.

(h) The administration of the duties and functions of the Secretary, insofar as they involve making determinations as to whether an organization is a qualified health maintenance organization within the meaning of subsection (d), shall be [administered through the Assistant Secretary for Health and in the Office of the Assistant Secretary for Health, and the administration of such duties and functions shall be] integrated with the administration of section 1312[a].

CONTINUED REGULATION OF HEALTH MAINTENANCE ORGANIZATIONS

SEC. 1312. (a) If the Secretary determines that an entity which received a grant, contract, loan, or loan guarantee under this title as a health maintenance organization or which was included in a health benefits plan offered to employees pursuant to section 1310—

(1) fails to provide basic and supplemental services to its members,

(2) fails to provide such services in the manner prescribed by section 1301(b), [or]

(3) is not organized or operated in the manner prescribed by section 1301(c), *or*

(*4*) *fails to meet the requirements of paragraph (2), (3), or (4) of section 1310(d) or to act in accordance with assurances provided under paragraph (3)(B) of such section,*

the Secretary may take the action authorized by subsection (b).

(b)(1) If the Secretary makes, with respect to any entity which provided assurances to the Secretary under section 1310(d)(1), a determination described in subsection (a), the Secretary shall notify the entity in writing of the determination. Such notice shall specify the manner in which the entity has not complied with such assurances and direct that the entity initiate (within 30 days of the date the notice is issued by the Secretary or within such longer period as the Secretary determines is reasonable) such action as may be necessary to bring (within such period as the Secretary shall prescribe) the entity into compliance with the assurances. If the entity fails to initiate corrective action within the period prescribed by the notice or fails to comply with the assurances within such period as the Secretary prescribes (A) the entity shall not be a qualified health maintenance organization for purposes of section 1310 until such date as the Secretary determines that it is in compliance with the assurances, and (B) each employer which has offered membership in the entity in compliance with section 1310, each lawfully recognized collective bargaining representative or other employee representative which represents the employees of each such employer, and the members of such entity shall be notified by the entity that the entity is not a qualified health maintenance organization for purposes of such section. The notice required by clause (B) of the preceding sentence shall contain, in readily understandable language, the reasons for the determination that the entity is not a qualified health maintenance organization. The Secretary shall publish in the Federal Register each determination referred to in this paragraph.

(2) If the Secretary makes, with respect to an entity which has received a grant, contract, loan, or loan guarantee under this title, a determination described in subsection (a), the Secretary may, in addition to any other remedies available to him, bring a civil action in the United States district court for the district in which such entity is located to enforce its compliance with the assurances it furnished respecting the provision of basic and supplemental health services or its organization or operation, as the case may be, which assurances were made in connection with its application under this title for the grant, contract, loan, or loan guarantee.

[(c) The Secretary, acting through the Assistant Secretary for Health, shall administer subsections (a) and (b) in the Office of the Assistant Secretary for Health.]

LIMITATION ON SOURCE OF FUNDING FOR HEALTH MAINTENANCE ORGANIZATIONS

SEC. 1313. No funds appropriated under any provision of this Act other than this title may be used—

(1) for grants or contracts for surveys or other activities to determine the feasibility of developing or expanding health maintenance organizations or other entities which provide, directly or indirectly, health services to a defined population on a prepaid basis;

(2) for grants or contracts, or for payments under loan guarantees, for planning projects for the establishment or expansion of such organizations or entities;

(3) for grants or contracts, or for payments under loan guarantees, for projects for the initial development or expansion of such organizations or entities; or

(4) for loans, or for payments under loan guarantees, to assist in meeting the costs of the initial operation after establishment or expansion of such organizations or entities.

The preceding sentence does not prohibit the use of funds appropriated under section 319 or 330 of this Act for grants to an entity, other than a health maintenance organization, for the planning and development of health services to be provided on a prepaid basis or for the provision of health services on a prepaid basis.

* * * * * * *

TRAINING AND TECHNICAL ASSISTANCE

SEC. 1317. (a) (1) The Secretary shall establish a National Health Maintenance Organization Intern Program (hereinafter in this subsection referred to as the "Program") for the purpose of providing training to individuals to become administrators and medical directors of health maintenance organizations or to assume other managerial positions with health maintenance organizations. Under the Program the Secretary may directly provide internships for such training and may make grants to or enter into contracts with health maintenance organizations and other entities to provide such internships.

(2) No internship may be provided by the Secretary and no grant may be made or contract entered into by the Secretary for the provision of internships unless an application therefor has been submitted to and approved by the Secretary. Such an application shall be in such form and contain such information, and be submited to the Secretary in such manner, as the Secretary shall prescribe. Section 1306 does not apply to an application submitted under this section.

(3) Internships under the Program shall provide for such stipends and allowances (including travel and subsistence expenses and dependency allowance allowances) for the recipients of the internships as Secretary deems necessary. An internship made to an individual for training at a health maintenance organization or any other entity shall also provide for payments to be made to the organization or other entity for the cost of support services (including the cost of salaries, supplies, equipment, and related items) provided such individual by such organization or other entity. The amount of any such payments to any organization or other entity shall be determined by the Secretary and shall bear a direct relationship to the reasonable costs of the organization or other entity for establishing and maintaining its training programs.

(4) Payments under grants under the Program may be made in advance or by way of reimbursement, and at such intervals and on such conditions, as the Secretary finds necessary.

(b) The Secretary shall provide (directly, through contracts, or both) technical assistance to (1) entities engaged in surveys or other activities to determine the feasibility of developing and operating or expending the operation of a health maintenance organization, (2) entities engaged in the planning for the initial development of health

maintenance organizations, (3) entities engaged in the initial development of health maintenance organizations, and (4) health maintenance organizations in connection with their operation.

(c) The authority of the Secretary to enter into contracts under subsections (a) and (b) shall be effective for any fiscal year only to such extent or in such amounts as are provided in advance by appropriation Acts.

* * * * * * *

SOCIAL SECURITY ACT

* * * * * * *

TITLE XI—GENERAL PROVISIONS AND PROFESSIONAL STANDARDS REVIEW

PART A—GENERAL PROVISIONS

* * * * * * *

LIMITATION ON FEDERAL PARTICIPATION FOR CAPITAL EXPENDITURES

SECTION 1122. (a) The purpose of this section is to assure that Federal funds appropriated under title V, XVIII, and XIX are not used to support unnecessary capital expenditures made by or on behalf of health care facilities [or health maintenance organizations] which are reimbursed under any of such titles and that, to the extent possible, reimbursement under such titles shall support planning activities with respect to health services and facilities in the various States.

(b) The Secretary, after consultation with the Governor (or other chief executive officer) and with appropriate local public officials, shall make an agreement with any State which is able and willing to do so under which a designated planning agency (which shall be an agency described in clause (ii) of subsection (d)(1)(B) that has a governing body or advisory board at least half of whose members represent consumer interests) will—

(1) make, and submit to the Secretary together with such supporting materials as he may find necessary, findings and recommendations with respect to capital expenditures proposed by or on behalf of any health care facility [or health maintenance organization] in such State within the field of its responsibilities.

(2) receive from other agencies described in clause (ii) of subsection (d)(1)(B), and submit to the Secretary together with such supporting material as he may find necessary, the findings and recommendations of such other agencies with respect to capital expenditures proopsed by or on behalf of health care facilities [or health maintenance organizations] in such State within the fields of their respective responsibilities, and

(3) establish and maintain procedures pursuant to which a person proposing any such capital expenditure may appeal a recommendation by the designated agency and will be granted

an opportunity for a fair hearing by such agency or person other than the designated agency as the Governor (or other chief executive officer) may designate to hold such hearings,

whenever and to the extent that the findings of such designated agency or any such other agency indicate that any such expenditure is not consistent with the standards, criteria, or plans developed pursuant to the Public Health Service Act (or the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963) to meet the need for adequate health care facilities in the area covered by the plan or plans so developed.

(c) The Secretary shall pay any such State from the Federal Hospital Insurance Trust Fund, in advance or by way of reimbursement as may be provided in the agreement with it (and may make adjustments in such payments on account of overpayments or underpayments previously made), for the reasonable cost of performing the functions specified in subsection (b).

(d) (1) Except as provided in paragraph (2), if the Secretary determines that—

(A) neither the planning agency designated in the agreement described in subsection (b) nor an agency described in clause (ii) of subparagraph (B) of this paragraph had been given notice of any proposed capital expenditure (in accordance with such procedure or in such detail as may be required by such agency) at least 60 days prior to obligation for such expenditure; or

(B) (i) the planning agency so designated or an agency so described had received such timely notice of the intention to make such capital expenditure and had, within a reasonable period after receiving such notice and prior to obligation for such expenditure, notified the person proposing such expenditure that the expenditure would not be in conformity with the standards, criteria, or plans developed by such agency or any other agency described in clause (ii) for adequate health care facilities in such State or in the area for which such other agency has responsibility, and

(ii) the planning agency so designated had, prior to submitting to the Secretary the findings referred to in subsection (B)—

(I) consulted with, and taken into consideration the findings and recommendations of, the State planning agencies established pursuant to sections 314(a) and 604(a) of the Public Health Service Act (to the extent that either such agency is not the agency so designated) as well as the public or nonprofit private agency or organization responsible for the comprehensive regional, metropolitan area, or other local area plan or plans referred to in section 314(b) of the Public Health Service Act and covering the area in which the health care facility [or health maintenance organization] proposing such capital expenditure is located (where such agency is not the agency designated in the agreement), or, if there is no such agency, such other public or nonprofit private agency or organization (if any) as performs, as determined in accordance with criteria included in regulations, similar functions, and

(II) granted to the person proposing such capital expenditure an opportunity for a fair hearing with respect to such findings;

then, for such period as he finds necessary in any case to effectuate the purpose of this section, he shall, in determining the Federal payments to be made under titles V, XVIII, and XIX with respect to services furnished in the health care facility for which such capital expenditure is made, not include any amount which is attributable to depreciation, interest on borrowed funds, a return on equity capital (in the case of proprietary facilities), or other expenses related to such capital expenditure. With respect to any organization which is reimbursed on a per capita or a fixed fee or negotiated rate basis, in determining the Federal payments to be made under titles V, XVIII, and XIX, the Secretary shall exclude an amount which in his judgment is a reasonable equivalent to the amount which would otherwise be excluded under this subsection if payment were to be made on other than a per capita or a fixed fee or negotiated rate basis.

(2) If the Secretary, after submitting the matters involved to the advisory council established or designated under subsection (i), determines that an exclusion of expenses related to any capital expenditure of any health care facility [or health maintenance organization] would discourage the operation or expansion of such facility [or organization, or of any facility of such organization,] which has demonstrated to his satisfaction proof of capability to provide comprehensive health care services (including institutional services) efficiently, effectively, and economically, or would otherwise be inconsistent with the effective organization and delivery of health services or the effective administration of title V, XVIII, or XIX, he shall not exclude such expenses pursuant to paragraph (1).

(e) Where a person obtains under lease or comparable arrangement any facility or part thereof, or equipment for a facility, which would have been subject to an exclusion under subsection (d) if the person had acquired it by purchase, the Secretary shall (1) in computing such person's rental expense in determining the Federal payments to be made under titles V, XVIII, and XIX with respect to services furnished in such facility, deduct the amount which in his judgment is a reasonable equivalent of the amount that would have been excluded if the person had acquired such facility or such equipment by purchase, and (2) in computing such person's return on equity capital deduct any amount deposited under the terms of the lease or comparable arrangement.

(f) Any person dissatisfied with a determination by the Secretary under this section may within six months following notification of such determination request the Secretary to reconsider such determination. A determination by the Secretary under this section shall not be subject to administrative or judicial review.

(g) For the purposes of this section, a "capital expenditure" is an expenditure which, under generally accepted accounting principles, is not properly chargeable as an expense of operation and maintenance and which (1) exceeds $100,000, (2) changes the bed capacity of the facility with respect to which such expenditure is made, or (3) substantially changes the services of the facility with respect to which

such expenditure is made. For purposes of clause (1) of the preceding sentence, the cost of the studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisition, improvement, expansion, or replacement of the plant and equipment with respect to which such expenditure is made shall be included in determining whether such expenditure exceeds $100,000.

(h) The provisions of this section shall not apply to Christian Science sanatoriums operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts.

(i) (1) The Secretary shall establish a national advisory council, or designate an appropriate existing national advisory council, to advise and assist him in the preparation of general regulations to carry out the purposes of this section and on policy matters arising in the administration of this section, including the coordination of activities under this section with those under other parts of this Act or under other Federal or federally assisted health programs.

(2) The Secretary shall make appropriate provision for consultation between and coordination of the work of the advisory council established or designated under paragraph (1) and the Federal Hospital Council, the National Advisory Health Council, the Health Insurance Benefits Advisory Council, and other appropriate national advisory councils with respect to matters bearing on the purposes and administration of this section and the coordination of activities under this section with related Federal health programs.

(3) If an advisory council is established by the Secretary under paragraph (1), it shall be composed of members who are not otherwise in the regular full-time employ of the United States, and who shall be appointed by the Secretary without regard to the civil service laws from among leaders in the fields of the fundamental sciences, the medical sciences, and the organization, delivery, and financing of health care, and persons who are State or local officials or are active in community affairs or public or civic affairs or who are representative of minority groups. Members of such advisory council, while attending meetings of the council or otherwise serving on business of the council, shall be entitled to receive compensation at rates fixed by the Secretary, but not exceeding the maximum rate specified at the time of such service for grade GS–18 in section 5332 of title 5, United States Code, including traveltime, and while away from their homes or regular places of business they may also be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703(b) of such title 5 for persons in the Government service employed intermittently.

* * * * * * *

TITLE XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

* * * * * * *

STATE PLANS FOR MEDICAL ASSISTANCE

SEC. 1902. (a) A State plan for medical assistance must—

(1) * * *

(1) * * *

* * * * * * *

(4) provide (A) such methods of administration (including methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods, and including provision for utilization of professional medical personnel in the administration and, where administered locally, supervision of administration of the plan) as are found by the Secretary to be necessary for the proper and efficient operation of the plan, [and] (B) for the training and effective use of paid subprofessional staff, with particular emphasis on the full-time or part-time employment of recipients and other persons of low income, as community service aides, in the administration of the plan and for the use of nonpaid or partially paid volunteers in a social service volunteer program in providing services to applicants and recipients and in assisting any advisory committees established by the State agency, *and (C) that each State or local officer or employee who is responsible for the expenditure of substantial amounts of funds under the State plan, each individual who formerly was such an officer or employee, and each partner of such an officer or employee shall be prohibited from committing any act, in relation to any activity under the plan, the commission of which, in connection with any activity concerning the United States Government, by an officer or employee of the United States Government, an individual who was such an officer or employee, or a partner of such an officer or employee is prohibited by section 207 or 208 of title 18, United States Code*;

PAYMENT TO STATES

SEC. 1903. (a) * * *

* * * * * * *

(m)(1)(A) * * *

* * * * * * *

(B) The duties and functions of the Secretary, insofar as they involve making determinations as to whether an organization is a health maintenance organization within the meaning of subparagraph (A), [shall be administered through the Assistant Secretary for Health and in the Office of the Assistant Secretary for Health, and the administration of such duties and functions] shall be integrated with the administration of section 1312 (a) and (b) of the Public Health Service Act.

* * * * * * *

XIII. SEPARATE AND DISSENTING VIEWS

Separate Views of Hon. Samuel L. Devine and Hon. James M. Collins of Texas

The Health Maintenance Organization Act of 1973 authorized a program to help develop new HMOs and expand existing ones by providing financial assistance through grants, contracts, and loans. By the end of 1977, a total of 172 organizations had received a total of $131.3 million in loans and grants. Of those, 80 which received a total of $8.5 million have either abandoned plans to begin business operations or have been determined not to be feasible organizations.

The Federal HMO program has been subjected to repeated criticism by the General Accounting Office (GAO). The most recent report was dated June 30, 1978, and was an evaluation of 14 Federally qualified HMOs (by the end of 1977 there were 51 qualified HMO's). The GAO found that some of the HMOs may not meet the Act's financial soundness requirement. Only three of the fourteen have a good chance of achieving financial independence within their first five years of operation after qualification. On the other hand, five have a fair chance and six have a poor chance.

The GAO recommended that Congress defer action on proposals to increase total loans available to individual HMOs until HEW demonstrates that it can effectively administer the existing loan program.

HEW observed that draft loan policies have been developed, that guidelines to administer the program more effectively and uniformly will be issued shortly, and additional personnel have been added to the loan branch. Nevertheless, GAO was unimpressed and continued to believe that the government should not be exposed to additional financial risk until HEW demonstrates that it can effectively monitor HMO's financial performance. (p. 62 of GAO Report.)

The Permanent Subcommittee on Investigations of the Senate Committee on Governmental Affairs issued a report on April 20, 1978, that was highly critical of the Federal HMO program. Among its observations were the following:

> "The Federal program has not, and is not, adequately organized and staffed to regulate HMO's so as to assure the public of the quality medical review and fiscal integrity expected of Federally certified HMO's." (p. 41)
>
> "loans totaling more than $2 million to two Federally qualified HMO's in Florida and Oregon are in trouble and the Federal Government may not get its money back." (p. 43)
>
> William McLeod, Director of the HMO Qualification and Compliance Office said that he felt "a moratorium was in order so that we could get our house in order to address many of these [problems], plus give us a chance to revise our application review process and work out the existing backlog." (p. 44)

> Dr. William Munier, Director of the HEW Office of Quality Standards, stated that the "present situation can best be summarized as an imminent disaster * * * [and] * * * is the logical product of devoting nearly all resources on the immediate problems of qualifications and neglecting the qualified HMO's." (p. 45)

In light of the above disquieting observations, what does the Committee propose to do with respect to financial assistance to HMOs? Why increase it, of course. Section 6 of H.R. 13655 amends Section 1305 of the Public Health Service Act to expand the support that may be provided to an HMO for its initial costs of operation to an aggregate amount of $4 million of loans or loan guarantees (with a $2 million limit in any one year). Further, such support could now include capital costs such as acquiring equipment. By contrast, under existing law an HMO is limited to $2.5 million (with a $1 million limit in any one year).

Also, under Section 9 a new section would be added to the law to provide up to $2.5 million in loans and loan guarantees to an HMO for the acquisition and construction of ambulatory health care facilities.

These expanded authorities are completely unwarranted in view of HEW's track record with respect to the existing HMO program.

Restraint should also have been placed on the total authorizations for the program which are to be increased from $50 million to some $63 million for each of fiscal years 1980 and 1981. Indeed, we should have delayed such future authorizations pending vigorous oversight by our Committee and substantial improvement by HEW.

Finally, it was reported in the August 7, 1978 Washington Report on Medicine and Health that HEW is looking deeper into potential problem HMOs and is finding material that, according to an internal memorandum, is "very serious and requires fast action on our part." They include some projects with loan advance problems, those "way behind in enrollments and revenues," and others that "have been having trouble almost from the start." All of this has a familiar, but deplorable, ring.

Samuel L. Devine.
James M. Collins.

Dissenting Views of Hon. John E. Moss, Hon. John D. Dingell, Hon. Henry A. Waxman, Hon. Albert Gore, Jr., and Hon. Marc L. Marks

H.R. 13655, in the form it was reported by the Subcommittee on Health and the Environment, should enhance the growth and development of Health Maintenance Organizations (HMOs) throughout the country. Many of its reforms are needed if independent, viable and competitive HMOs are to develop.

However, because H.R. 13655 was reported out of the Interstate and Foreign Commerce Committee with an amendment, now Section 14, it is incumbent upon us to vigorously voice our objection and urge Members to delete that section from the bill. Section 14 would allow certain existing HMOs to escape the governing board requirements of existing laws. This is an unwarranted suspension of the already limited public accountability of these organizations.

Section 14 will make existing HMOs sponsored by commercial insurance carriers and non-profit carriers (Blue Cross/Blue Shield) eligible for a waiver of the one-third consumer representation requirement. This circumvents the original intent of Congress that members of an HMO, health care consumers, be able to participate in the management of the HMO at the policy-making level. During recent hearings before the Senate Finance Committee, numerous examples of fraud and abuse in the management and marketing of HMOs were disclosed. Removing the members' voice in the management of the HMO will eliminate an important mechanism for the deterence of abusive practices.

We note with particular distress the effect this amendment will have on competition in the health care marketplace. Although the amendment covers commercial insurers and Blue Cross/Blue Shield plans, the sponsors of the amendment are the Blue Cross/Blue Shield plans. Blue Cross/Blue Shield currently has about 40% of the third party payer market and is the dominant competitor with HMOs. Section 14 may increase their power in the marketplace.

The Subcommittee on Oversight and Investigation has held five days of hearings during this Congress on the activities of Blue Shield. The Subcommittee heard from the Assistant Attorney General of the State of Ohio indicating that when the first HMO was being established in Cincinnati, Ohio, the Blue Shield plan there attempted to impede its growth. When it became apparent that stopping the HMO was not feasible, the plan was instructed by its parent organization, the Ohio State Medical Association, to put enough money into the HMO to control it. With this as an example of one non-profit carrier's anti-competitive activities, it seems unjustifiable to allow these organizations even greater latitude for manipulation. Under existing law, commercial and non-profit carriers can control at least two-thirds of an HMOs governing board. Why should we allow these organiza-

tions to choose the remaining third without mandating at least this minimal representation of enrollees who are to be served by the HMO and who ought to have the opportunity to raise issues of special concern. Relegating them to an advisory board only is insufficient.

Blue Cross governing boards appear to be controlled by hospital administrators; while Blue Shield boards are controlled by physicians. Thirty-six of the sixty-nine Blue Shield governing boards have physician majorities. The number grows to forty-four when hospital administrators are counted to form "provider majorities." Most plans also have a majority of physicians on their fee setting and review committees or the committees are completely composed of physicians. It seems inconsistent with the intent of the HMO legislation to allow these groups to receive waivers.

It has been argued that the one-third consumer representation requirement is particularly difficult for Blue Cross/Blue Shield. But no explanation of why this is so has been put forward. It should be noted that this amendment only allows plans that came into existence prior to July 1, 1978 (of which there are fourteen) to apply for a waiver. Any new plan must meet the requirements of existing law. This strongly suggests that the problems to which they allude are not serious. It simply grandfathers existing plans, a majority of which were started after the passage of the HMO Act of 1973 full cognizance of the requirements of the law.

Why is the Congress being asked to waive one of the few requirements that assures at least minimal public accountability of existing HMOs? As the Health Insurance Association of America, representing over 300 insurance companies, is strenuously opposing this amendment, we can assume that only Blue Cross/Blue Shield would like our support for provider domination and the reduction of competition it would produce.

In conclusion, we submit that the proponents of Section 14 of the HMO Amendments of 1978 have shown no justification for its inclusion in the bill. To the contrary, all the evidence that we have seen demonstrates a fundamental need for increased consumer representation to assure greater public accountability. We hope you will join with us in opposing this special interest provision.

John D. Dingell.
Albert Gore, Jr.
Marc L. Marks.
John E. Moss.
Henry A. Waxman.

○